FARHA
ATTORNEY AT LAW

New Client Personal Injury Intake Form

I. Client Information:

Date: _____

Full Legal Name: _____

Address, City , State , Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

II. Personal Information:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse's Name/Significant Other: _____

Children/Names/Ages: _____

Drivers License Number: _____

Date of Birth: _____

Referred by: _____

Social Security Number: _____

Name of Emergency Contact: _____

Relationship: _____

Emergency Contact Information: _____

II. Personal Information Continued:

Prior Criminal Record? ☐ Yes ☐ No

Explain: _____

Prior Traffic Citations? ☐ Yes ☐ No

Explain: _____

Do You Use Social Media? ☐ Yes ☐ No

List and and all, i.e. Facebook, Twitter, etc.: _____

III. Accident Information:

Date of Accident: _____

Statue of Limitations: _____

Time Of Accident: _____

Location: _____

How did the accident happen?

_____

Passengers in vehicle? _____

Investigated by Police? ☐ Yes ☐ No

Accident Report Obtained? ☐ Yes ☐ No

Incident Number: _____

Statements given to anyone: ☐ Yes ☐ No

To whom?

_____

III. Accident Information Continued:

Tickets or Citations Issued? ☐ Yes ☐ No

To Which Party? _____

Ticket or Citation Number: _____

IV. Injuries:

Injuries Sustained in this Accident: _____

Prior Injuries: _____

Pre-Existing Conditions: _____

Medical Conditions/Diseases: _____

V. Client's Insurance Information:

Insurance Company: _____

Agent's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Policy Number: _____

Claim Number: _____

Liability Coverage: ☐ Yes If so , how much? _____

☐ No

V. Client's Insurance Information Continued:

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? _____

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? _____

Collision: ☐ Yes ☐ No If so, how much? _____

Rental: ☐ Yes ☐ No If so, how much? _____

Claims Adjuster: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Med-Pay Adjuster: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

VI. Client's Insurance Information 2:

(Please complete for each insurance policy (commercial or personal) which insures any vehicle owned by you or anyone in your household.)

Insurance Company: _____

Agent's Name: _____

VI. Client's Insurance Information 2 Continued:

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Policy Number: _____

Claim Number: _____

Liability Coverage: ☐ Yes ☐ No If so , how much? _____

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? _____

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? _____

Collision: ☐ Yes ☐ No If so, how much? _____

Rental: ☐ Yes ☐ No If so, how much? _____

Claims Adjuster: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Med-Pay Adjuster: _____

Address: _____

Phone Number: _____

Fax Number: _____

VI. Client's Insurance Information 2 Continued:

E-Mail: _____

VII. Client's Vehicle Information:

Year: _____

Make: _____

Model: _____

Color: _____

Mileage and General Vehicle Information: _____

Name of Towing Company: _____

Do you Own Any Other Vehicles? (Car, Truck, RV, Motorcycle) ☐ Yes ☐ No

If you answered yes, please provide the following information for each vehicle:

Insurance Information:

Insurance Company: _____

Agent's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Policy Number: _____

Claim Number: _____

Liability Coverage: ☐ Yes If so , how much? _____
☐ No

VII. Clients Vehicle Information Continued.

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? _____

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? ____

Collision: ☐ Yes ☐ No If so, how much? _____

Rental: ☐ Yes ☐ No If so, how much? _____

Does a Family Member in Your Household own a Vehicle? ☐ Yes ☐ No

If you answered yes, please provide the following information for each vehicle:

Insurance Information:

Insurance Company: _____

Agent's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail _____

Policy Number: _____

Claim Number: _____

Liability Coverage: ☐ Yes ☐ No If so , how much? _____

Under/Uninsured Coverage: ☐ Yes ☐ No If so, how much? _____

VII. Client's Vehicle Information Continued:

Medical Payment/Med-Pay: ☐ Yes ☐ No If so, how much? _____

Collision: ☐ Yes ☐ No If so, how much? _____

Rental: ☐ Yes ☐ No If so, how much? _____

VIII. Client's Health Insurance Information:

Name of Insured: _____

Insurance Company _____

Address: _____

Phone: _____

Policy Number: _____

Group Number: _____

Identification Number: _____

Type of Coverage: _____

Medicare: ☐ Yes ☐ No

Medicare Number: _____

Medicaid ☐ Yes ☐ No

Medicaid Number: _____

IX. Medical Treatment Information:

(Please list all doctors including Ambulance and ER visits since the date of the accident)

Ambulance? ☐ Yes ☐ No

Name of Ambulance Service: _____

IX. Medical Treatment Information Continued:

Do You have Copies of Medical Bills and Records? ☐ Yes ☐ No

Emergency Room? ☐ Yes ☐ No

Name of Emergency Room? _____

Who has paid your medical bills? _____

Medical Providers (Doctors, Physical Therapy, Chiropractor, MRI, etc...):

Medical Facility 1: _____

Treating Physician /Physical Therapist/ Chiropractor: _____

Dates of Service: _____

Facility Address: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Medical Facility 2: _____

Treating Physician /Physical Therapist/ Chiropractor: _____

Dates of Service: _____

Facility Address: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Medical Facility 3: _____

Treating Physician /Physical Therapist/ Chiropractor: _____

IX. Medical Treatment Information Continued:

Dates of Service: _____

Facility Address: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Medical Facility 4: _____

Treating Physician /Physical Therapist/ Chiropractor: _____

Dates of Service: _____

Facility Address: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

Medical Facility 5: _____

Treating Physician /Physical Therapist/ Chiropractor: _____

Dates of Service: _____

Facility Address: _____

Phone Number: _____

Fax Number: _____

E-mail: _____

X. Property Damage Information:

Property Damage Already Collected on Your Vehicle? ☐ Yes ☐ No

Do You have and Estimate for Property Damage? ☐ Yes ☐ No

Do You have Pictures of Your Vehicle? ☐ Yes ☐ No

XI. Lost Wages:

Did you Miss Work as a Result of this Accident? ☐ Yes ☐ No

Employer: _____

Contact Name & Phone Number: _____

If so, who can verify your lost wages? _____

Rate of Pay: _____ Paid how Often? _____

XII. Defendant's Insurance Information:

Is there more than one defendant? If so, please enter all of the following information for each defendant. ☐ Yes ☐ No

Defendant 1

Defendant's Insurance Company: _____

Policy Number: _____

Claim Number: _____

Full Legal Name: _____

XII. Defendant's Insurance Information Continued:

Address, City , State , Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Drivers License Number: _____

Date of Birth: _____

Social Security Number: _____

Name of Owner of Vehicle: (if different from driver) _____

Relationship Between Driver and Owner:

- ☐ Employer-Employee
- ☐ Parent-Child
- ☐ Family
- ☐ Friend
- ☐ Other

Bodily Injury Adjuster's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

Property Adjuster's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

XII. Defendant's Insurance Information Continued:

Any Additional Notes or Information: _____

Defendant 2

Defendant's Insurance Company: _____

Policy Number: _____

Claim Number: _____

Full Legal Name: _____

Address, City , State , Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Drivers License Number: _____

Date of Birth: _____

Social Security Number: _____

Name of Owner of Vehicle: (if different from driver) _____

Relationship Between Driver and Owner:

- ☐ Employer-Employee
- ☐ Parent-Child
- ☐ Family
- ☐ Friend
- ☐ Other

Bodily Injury Adjuster's Name: _____

Address: _____

Phone Number: _____

XII. Defendant's Insurance Information Continued:

Fax Number: _____

E-Mail: _____

Property Adjuster's Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

Any Additional Notes or Information: _____

Other Important Information and Notes: _____

Copies to Bring with You

- ◯ Drivers License
- ◯ Health Insurance Card
- ◯ Car Insurance Card
- ◯ Declarations Sheet
- ◯ Medical Records
- ◯ Medical Bills
- ◯ Photographs of Client Vehicle
- ◯ Photographs of Defendant Vehicle
- ◯ Photographs of Injuries

Disclaimer: The submission of information does NOT establish an attorney-client relationship. This form is for case evaluation purposes. Please contact attorney's office. if you would like to discuss hiring/retaining an attorney.