AUTO ACCIDENT INTAKE INFORMATION

DATE\TIME OF ACCIDENT: ____

LOCATION OF ACCIDENT: ____

DESCRIBE WHAT HAPPENED:

____

____

____

____

____

____

ACCIDENT DRAWING:

INFORMATION ABOUT CAR CLIENT WAS IN:

YEAR: ________________ MAKE: ______________________ MODEL: ________________________

OWNER'S NAME: ____

CAR DRIVE-ABLE AFTER ACCIDENT: ____

ESTIMATE OBTAINED FOR COST TO REPAIR: ____

REPAIR COMPANY NAME:____

COST TO REPAIR: ____

NAMES AND WHERE SEATED OF ALL PERSONS IN THE CAR AT TIME OF ACCIDENT:

1. DRIVER:____

DRIVER INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

2. FRONT RIGHT: ___________________________________ NONE ________

PERSON INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

3. FRONT CENTER: _________________________________ NONE _________

PERSON INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

4. BEHIND DRIVER:_________________________________ NONE _________

PERSON INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

5. BACK SEAT CENTER: ____________________________ NONE _________

PERSON INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

6. BACK SEAT RIGHT: ______________________________ NONE _________

PERSON INJURED? YES _________ NO ________

If yes, describe injuries: ____________________________

____

WEARING SEAT BELT? YES _________ NO ________

AIR BAG DEPLOY? YES _________ NO ________

PERSONAL INFORMATION FOR #1 (DRIVER), ABOVE:

NAME: _________________________________ BIRTH DATE: _________________________

IF MARRIED, SPOUSE'S NAME _________________ SOCIAL SECURITY NO*:________________

ADDRESS: _________________________________ DRIVER'S LICENSE NO: ________________

_________________________________ PHONE: ______________________________

EMAIL: _________________________________ RECEIVING MEDICARE? _______________

PERSONAL INFORMATION FOR #2, ABOVE:

NAME: _________________________________ BIRTH DATE: _________________________

SPOUSE'S NAME: _____________________________ SOCIAL SECURITY NO*: _______________

ADDRESS: _________________________________

_________________________________ PHONE: ______________________________

EMAIL: _________________________________ RECEIVING MEDICARE? _______________

PERSONAL INFORMATION FOR #3, ABOVE:

NAME: _________________________________ BIRTH DATE: _________________________

SPOUSE'S NAME: ____________________________ SOCIAL SECURITY NO*: _______________

ADDRESS: _________________________________

_________________________________ PHONE: ______________________________

EMAIL: _________________________________ RECEIVING MEDICARE? _______________

PERSONAL INFORMATION FOR #4, ABOVE:

NAME: _________________________________ BIRTH DATE: _________________________

SPOUSE'S NAME: ____________________________ SOCIAL SECURITY NO*: _______________

ADDRESS: _________________________________

_________________________________ PHONE: ______________________________

EMAIL: _________________________________ RECEIVING MEDICARE? _______________

PERSONAL INFORMATION FOR #5, ABOVE:

NAME: ______________________ BIRTH DATE: ______________________

SPOUSE'S NAME: ______________________ SOCIAL SECURITY NO*: ______________________

ADDRESS: ______________________

______________________ PHONE: ______________________

EMAIL: ______________________ RECEIVING MEDICARE? ______________________

PERSONAL INFORMATION FOR #6, ABOVE:

NAME: ______________________ BIRTH DATE: ______________________

SPOUSE'S NAME: ______________________ SOCIAL SECURITY NO*: ______________________

ADDRESS: ______________________

______________________ PHONE: ______________________

EMAIL: ______________________ RECEIVING MEDICARE? ______________________

****** PLEASE NOTE THAT SOCIAL SECURITY NUMBERS ARE NOW REQUIRED BECAUSE WHEN THE OTHER INSURANCE COMPANY PAYS OUT A SETTLEMENT IT MUST CONFIRM WHETHER CERTAIN FEDERAL BENEFITS ARE BEING RECEIVED BY THE INJURED PERSON. THE SOCIAL SECURITY NUMBER IS REQUIRED FOR THIS PURPOSE.**

CLIENT'S CAR INSURANCE INFORMATION:

CARRIER'S NAME: ______________________ ADJUSTER'S NAME: ______________________

ADDRESS: ______________________ DIRECT PHONE: ______________________

______________________ FAX: ______________________

EMAIL: ______________________

CLAIM #: ______________________

CLIENT'S HEALTH INSURANCE INFORMATION:

CARRIER'S NAME: ______________________ ADJUSTER: ______________________

ADDRESS: ______________________ DIRECT PHONE: ______________________

______________________ FAX: ______________________

EMAIL: ______________________

GROUP #: ______________________

MEMBER #: ______________________

IF ACCIDENT OCCURRED WHILE CLIENT ON-THE-JOB, EMPLOYER INFORMATION:

EMPLOYER'S NAME: ____________________ PHONE: ____________________

ADDRESS: ____________________ FAX: ____________________

____

WORKER'S COMPENSATION INSURER:

CARRIER'S NAME: ____________________ ADJUSTER: ____________________

ADDRESS: ____________________ PHONE: ____________________

____________________ FAX: ____________________

INSURED'S NAME: ____________________ EMAIL: ____________________

CLAIM NUMBER: ____________________

WAGE LOSS INFORMATION:

DID CLIENT LOSE TIME FROM WORK? ____________________

IF YES: AMOUNT OF TIME LOST: ____________________

RATE OF PAY: ____________________

"OTHER" DRIVER'S PERSONAL INFORMATION:

NAME: ____________________ CAR INFORMATION:

ADDRESS: ____________________ YEAR: ____________________

____________________ MAKE: ____________________

PHONE: ____________________ MODEL: ____________________

DOB: ____________________ DRIVER'S LICENSE #: ____________________

OTHER DRIVER'S INSURANCE INFORMATION:

CARRIER NAME: ______________________ ADJUSTER: ______________________

ADDRESS: ______________________ DIRECT PHONE: ______________________

______________________ FAX: ______________________

CLAIM #: ______________________ EMAIL: ______________________

WITNESS INFORMATION:

WITNESS #1: WITNESS #2:

NAME: ______________________ ______________________

ADDRESS: ______________________ ______________________

______________________ ______________________

PHONE: ______________________ ______________________

MEDICAL PROVIDERS WHO HAVE BEEN INVOLVED (INCLUDING, BUT NOT LIMITED TO, AMBULANCE, HOSPITALS, PRIMARY CARE PHYSICIANS, MEDICAL DOCTORS, CHIROPRACTORS, PHYSICAL THERAPISTS, MASSAGE THERAPISTS, AND OTHERS):

1. NAME: ______________________ ADDRESS: ______________________

____

PHONE: ______________________

2. NAME: ______________________ ADDRESS: ______________________

____

PHONE: ______________________

3. NAME: ______________________ ADDRESS: ______________________

____

PHONE: ______________________

4. NAME: ______________________________ ADDRESS: ____________________________________

____

PHONE: ____________________________________

**** PLEASE ATTACH ANOTHER PAGE IF NECESSARY TO LIST OTHER PROVIDERS ****

OTHER CONCERNS:

____

____

____

____

____

____

____

____

____

____