PERSONAL INJURY INFORMATION FORM

Full Name: ____

Driver: ( ) Passenger: F/R: ( ) R/L: ( ) R/C: ( ) R/R: ( )

Number of Years Living in Florida:______________________________
****Are you receiving: Medicare: (Y)__________ (N)__________
Medicaid: (Y)__________ (N)__________
SSI: (Y)__________(N)__________
SSD: (Y)__________(N)__________

Date of Accident:______________ Time of Accident:______________am/pm
Location:____
____

HEALTH INSURANCE: (PLEASE PROVIDE US A COPY OF THE CARD)

Carrier:____
Group #:______________________ ID#:______________________
Claims Address:____
Telephone #:____

OTHER HEALTH INSURANCE: (Secondary/Supplemental/Medicare, etc)

Carrier:____
Group #:______________________ ID#:______________________
Claims Address:____
Telephone #:____

YOUR AUTO INSURANCE: (PIP/UNINSURED MOTORIST)

Carrier:____
Insured:____
Policy No.:______________________ Claim No.:______________________
Adjuster's Name:______________________Phone #:______________________
Claims Address:____
Deductible: Amount, if any: $__________ Med-Pay: Amount, if any: $__________
Other Vehicles in Household/Owners/Policy Details:______________________
____

AT THE SCENE:

Description of the Accident:____
____
____

____
____
____
Witness(s): (Y)_____ (N)_____If yes, name, address and phone #:___________________
____

Were you wearing a seatbelt: (Y)___ (N)___If no, why not?_______________________
Citation Issued: (Y)____(N)____To Whom:____
Police Department:____________________________Case #__________________________

Did the defendant make any statements at the scene? If so, what was said:____________
____
____

PROPERTY DAMAGE:

Total Loss: (Y)_____(N)______Amount paid:$_____________________________________
Pictures: (Y)________(N)__________ Who took the pictures?_________________________
Location of related damage?
Is vehicle drivable? (Y)___________ (N)_________
Is vehicle at a body shop or tow yard? (Y)______________ (N)______________________
If so, name, address and phone #:____
____
____
Is there a storage charge? (Y)_______(N)_____If so, daily charge: $__________________

MEDICAL TREATMENT:

EMS: (Y)__________(N)__________ Name:_______________________________________
Treated on scene only: (Y)_______________(N)________________
Transported to a Hospital: (Y)____________(N)________________

HOSPITAL:____ Date:____________________
ER Only: (Y)_________(N)_________ X-rays taken: (Y)________(N)__________
Admitted: (Y)____________(N)_________
Surgery: (Y)________(N)__________Surgeon:_________________Date:________
Procedures:____
Rehab: (Y)_________(N)__________Where:_________________________________
Inpatient: (Y)_______(N)__________Dates:___________________________
Outpatient: (Y)____________(N)__________Dates:____________________

TREATING PHYSICIAN(S):____

____

____

INJURIES:____

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Please be able to provide to us a copy of the following items at your consultation if available:

Vehicle insurance policy(s).
Insurance card(s).
Health Insurance card(s)
Exchange of Information Report.
Crash Report.
Photos (of injuries and/or vehicle).
Medical Records.
Medical bills.

If you receive bills from any accident related medical providers, please inform us immediately. We will need copies of these bills.

______________________________ ________________________

Client Signature Date