

Marvin R. Jeffcoat, Esq.
Attorney at Law
PERSONAL INJURY/AUTO ACCIDENT
INTAKE FORM



Licensed to practice in CA, Federal Courts in the Central District of CA, District of CT and Northern District of FL Only

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Date: _____ Referred by: _____

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE? ___ YES ___ NO

IF SO, PLEASE GIVE NAME OF ATTORNEY: _____

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? ___ YES ___ NO

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)

DATE OF ACCIDENT: _____

S.O.L.: _____

CLIENT INFORMATION:

Name: _____ Tel: _____ (cell) (other): _____

Address: _____ Date of Birth: _____

Email: _____ SSN: _____

Nationality: _____ Place of Birth: _____

What Passports/Dual Citizenship Do You Have: _____

Gender: _____ Race/Ethnicity: _____ HT: _____ WT: _____

Eye Color: _____ Hair Color: _____

Employer: _____

Address: _____

Work Phone: _____ Ext.: _____

Fax: _____ Work Days/Hours: _____

How long have you worked there? _____

Immediate Supervisor: _____

Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____ Occupation: _____

Client's Employer: _____ Occupation: _____

Duties: _____

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Client's Employer: _____ Occupation: _____
Duties: _____

Prior **similar injuries**, treated medical conditions and/or symptoms to same area or current injury

(Dates/Drs.): _____

Prior **claims and/or settlements** (types, dates, attorneys):

List any **prior injury settlements**:

ACCIDENT INFORMATION

Person/Entity Causing the Accident: _____

Address: _____

Phone: _____ Email: _____

Date of Accident: _____ Day of Week: _____ Time: _____ am/pm

Where: (Be Specific) _____

Where were you coming from? _____

Where were you going? _____

DETAILS OF ACCIDENT:

Weather condition (if happened outside): _____

Any construction in the area? _____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC – GET AS MUCH DETAIL AS POSSIBLE)

Did this injury occur when you were driving a vehicle? ___ Yes ___ No

Were you driving a company vehicle? ___ Yes ___ No

What was the make, model and year of the vehicle you were driving? _____

Was anyone, including yourself, to the best of your knowledge, taking any medications or using any sort of drugs? ___ Yes ___ No

If so, please list _____

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Had anyone, including yourself, been drinking? ___ Yes ___ No

Did anyone make a statement at the scene? ___ Yes ___ No

If so, who? What was said?

To whom? _____

Were photographs taken of the scene? _____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: _____

Address: _____

Phone: _____

Agent's Name: _____

Address: _____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Cash Policy for Accidents: _____

Effective Dates of coverage: _____

Is this a WORKE'S COMP CLAIMS? _____

Are you covered through your employer's insurance? ___ Yes ___ No

If so, provide company and agent, if known: _____

Policy or plan number: _____

Name of insured: _____

Limits of coverage: _____

Did you file a claim with your insurance company? ___ Yes ___ No

Has anyone from the insurance company contacted you about this claim? ___ Yes ___ No

If yes, name of person who contacted you: _____

When was contact made? _____

If a statement was given, was it tape recorded or written? _____

Did you receive a copy? ___ Yes ___ No

Have you signed any authorizations to release information to anyone? ___ Yes ___ No

If so, identify: _____

Have you signed any releases? ___ Yes ___ No

If so, for whom? _____

Have you received any insurance benefits? ___ Yes ___ No

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? ___ Yes ___ No

If so, which agency? _____

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INSURANCE COVERAGE FOR DEFENDANT

Name of Carrier: _____

Address: _____

Phone: _____

Agent's Name: _____

Address: _____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

MEDICAL INFORMATION:

Were you injured in this accident? ___ Yes ___ No

If so, please describe:

Did you go to the hospital? ___ Yes ___ No

If so, which hospital: _____

Admitted or Outpatient? _____

If admitted, release date: _____

X-Rays taken? ___ Yes ___ No

Were you taken by ambulance? ___ Yes ___ No

(Please sign authorization for release form)

Are you under the care of a physician now? ___ Yes ___ No

Did you miss work due to the accident? ___ Yes ___ No

(If yes, please

LIST DOCTORS:

1. Name: _____ Phone: _____

Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___ Yes ___ No

Current Balance on Medical Bills: _____

2. Name: _____ Phone: _____

Address: _____

Telephone Number: _____

When did you last see the doctor? _____

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When will you see the doctor again? _____
Physical therapy? ___ Yes ___ No
Current Balance on Medical Bills: _____

3. Name: _____ Phone: _____
Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___ Yes ___ No

Current Balance on Medical Bills: _____

4. Name: _____ Phone: _____
Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___ Yes ___ No

Current Balance on Medical Bills: _____

5. Name: _____ Phone: _____
Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___ Yes ___ No

Current Balance on Medical Bills: _____

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR
CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN
FINISHED USING OR WHEN CAST IS REMOVED.

Was anyone else injured? ___ Yes ___ No

Who was injured? _____

Describe the injury: _____

NAME AND ADDRESSES OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

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WITNESSES:

1. Name and address: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ___ No

2. Name and address: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ___ No

3. Name and address: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ___ No

4. Name and address: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ___ No

5. Name and address: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ___ No

VIEWING THE SCENE:

Can we go to the accident scene? ___ Yes ___ No

Is the equipment available for inspection? ___ Yes ___ No

Who do we contact to arrange a viewing? _____

NAME AND ADDRESS: _____

Telephone Number: (____) _____

Job Title: _____

Can we photograph the equipment? ___ Yes ___ No

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Any other information you feel may assist us in representing you for this claim?

JURISDICTION: _____ POLICE DEPARTMENT: _____
Officer's Name: _____ Police Report No.: _____

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DIAGRAM OF HOW ACCIDENT OCCURRED:

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DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others):

Sports:

Social Activities:

Job Duties:

Household Chores:

Have you had to hire domestic help? ___ Yes ___ No

How do you feel you have been damaged emotionally by these injuries?

How do you feel you have been damaged financially by these injuries?
