Marvin R. Jeffcoat, Esq.
Attorney at Law

PERSONAL INJURY/AUTO ACCIDENT INTAKE FORM

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Date: _____ Referred by: _____

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

IF SO, PLEASE GIVE NAME OF ATTORNEY: _____

DO YOU HAVE A SINGED 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
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 _____
_____
_____
_____

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? _____
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:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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.): _____
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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?