PERSONAL INJURY INTAKE FORM

Motor Vehicle Accident

Thompson & Thompson, P.C.

PLAINTIFF'S (CLIENT) INFORMATION

Name:	
Address:	
Mailing Address: (*if different from above*)	
Telephone Number:	
Date of Birth:	
DATE OF ACCIDENT:	
Social Security Number:	

Additional Insurance Coverage:

Do you have an auto policy? _____;If so, state the following:

Name of the Insurer: _____
Name of the Insured:_____
Policy No.: _____
Amount of Coverage: _____

Are you insured under someone else's auto policy?_____; If so, state the following:

Name of the Insurer: _____
Name of the Insured: _____
Policy No.: _____
Amount of Coverage: _____

***If you live with your parents, list all auto policies in the household

***Provide a copy of the declaration page for all policies listed**

MEDICAL TREATMENT AS A RESULT OF ACCIDENT

Medical Provider	Address	MRN/Acct. No. (If known)

HEALTH INSURANCE INFORMATION

Please provide the following information for all health insurance plans you have had since the date of the accident and at the time of the accident. ***PROVIDE COPY OF ALL INSURANCE CARDS***

Health Insurance Company:	
Policy No./Subscriber ID:	
Account/Group No.:	

EMPLOYMENT

Were you employed at the time of the accident? _____; If so, provide the following information for the employer, if you have loss of wages as a result of the accident:

Name: _____
Address: _____
Telephone No. _____
Length of Employment: _____
Position: _____
Hourly pay: _____

Please provide the same information for your current employer, if different from above, if you are claiming loss of wages:

Name: _____
Address: _____
Telephone No. _____
Length of Employment: _____
Position: _____
Hourly pay: _____

** Were you unemployed at the time of the accident: ____ Yes _____ No

STATUS OF MEDICAL TREATMENT/MEDICAL CONDITION

Currently Treating _____; if so, name the provider you are treating with: _____

Discharged from treatment _____; if so, state whether you have been given a disability rating or have been advised you have permanent injury. _____

List the injuries sustained as a result of the accident:

State your current state of health as it relates to the injuries you sustained as a result of the accident i.e. are you still experiencing pain, location of pain etc.

Explain how your daily living has changed as a result of the injuries you sustained in the accident; list activities you are no longer able to do etc.

PREEXISTING CONDITION(S)

Explain, in detail, any and all preexisting medical conditions as they relate to the injuries you sustained in the accident.

Explain, in detail, ALL other preexisting medical conditions whether related to the injuries you sustained in the accident or not.

Explain in detail any prior accidents, including type of accident, injuries sustained etc.

Explain, in detail, how the accident occurred.

DEFENDANT'S (THE OTHER PARTY) INFORMATION

Name:	
Address (if known):	
Liability Carrier (if known):	
If a claim has been reported, provide the Adjuster's Name:	
Address:	
Telephone No.:	
Claim No.:	

If you recall, please provide a list of medical providers you saw during the10 year period PRIOR to the accident describing the reasons for each consult.

Provide the name of all medical providers you have seen since the accident, for any other reason other than accident related injuries, describing the reason for each consult.