HOW DID YOU FIND US? *{please mark any referral sources that apply}*

☐Previous Client ☐Office Sign ☐Qwest Dex ☐Yellow Book
☐Internet ☐AVVO ☐Other:_____
☐Friend *(see below)* ☐Physician *(see below)*

Name of person who referred you:
Their name: _____ Their phone: _____

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Initial Consultation Acknowledgement

Thank you for contacting our law office concerning your claims and for coming to our office for this free initial consultation. So that there are no misunderstandings, we like to set forth the basis upon which we will meet with you and have you acknowledge your understanding of this with your signature below:

1. The initial consultation is free of charge and there is no obligation;

2. Everything shared with the attorney in confidence is privileged and will be kept confidential. If you choose to have another person(s) with you during the consultation, please be aware that the confidentiality may be compromised and the privilege may be waived;

3. The initial consultation creates no relationship with the attorney or with the Law Firm. This means neither the attorney nor the Law Firm will perform any activities or representation on your behalf unless a fee agreement has been properly executed. An Attorney-Client relationship only arises after a fee agreement has been signed and dated by both the client and the attorney;

4. No legal advice will be rendered during the initial consultation;

5. If a fee agreement is provided to you, it must be signed, dated and returned within 10 days if you wish to retain the attorney, otherwise the document will be void and invalid.

I ACKNOWLEDGE MY UNDERSTANDING OF THESE ITEMS.

_____ _____
Signature Date

_____
Print Name

CONFIDENTIAL

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INCIDENT INFORMATION SHEET

Today's Date: ____/____/_____

CLIENT INFORMATION

Date of Accident: ____/____/_____

Full Name: _____ Driver or Passenger? (circle)
First Middle Last

Address: _____
Street City State Zip

Phone #: (___)____-_____ Work #: (___)____-_____ Cell#: (___)____-_____

Home E-Mail: _____ Work E-Mail: _____

Date of Birth: ____/____/_____ Social Security#: _____-____-_____ DL#: _____

Emergency Contact Name: _____
First Middle Last

Address: _____
Street City State Zip

Phone #: (___)____-_____ Work #: (___)____-_____ Cell#: (___)____-_____

Spouse's full name, if married: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Mother: _____ Phone#: (___)____-_____

Father: _____ Phone#: (___)____-_____

ACCIDENT INFORMATION

Time of Incident: _____ AM or PM?

Place of Incident: _____ County: _____

Street/Intersection (if applicable): _____

WERE THE POLICE CALLED TO THE SCENE? Yes _____ No_____

WAS AN ACCIDENT OR ACCIDENT REPORT FILED? Yes _____ No_____

IF THE POLICE DID NOT file an Accident Report, did you file a Cold Report? Yes or No

IF yes, please state the accident report number: _____

UNDERSTANDING OF HOW THE ACCIDENT OCCURRED: _____

_____

_____

_____

_____

Please list the following with respect to any independent witnesses:

Witness 1:_____Phone number: (___)____-_____
First Last

Address: _____
Street City State Zip

Witness 2:_____Phone number: (___)____-_____
First Last

Address: _____
Street City State Zip

YOUR PASSENGERS/COMPANIONS(who were injured) *For more space, use back of page.*

Full Name: _____Contact#: (___)____-_____
First Middle Last

Address: _____
Street City State Zip

Date of Birth: ____/____/_____ Social Security#: _____-____-_____ DL#: _____

INJURIES:_____

Did the above go to the Hospital? Yes ____ No____ _____
Name of Hospital

Transported by Ambulance? Yes ____ No____ _____
Name of Ambulance Service

X-rays/imaging? Yes ____ No____

ABOVE SEEING A DOCTOR NOW? Yes ____ No____(list all doctors below)

_____
Name Address Phone Number

_____
Name Address Phone Number

AT-FAULT PARTY AND AUTOMOBILE INSURANCE

Driver's name: _____ Phone number: (___)____-_____

Address: _____
Street City State Zip

Date of Birth (if known): ____/____/_____ Driver's License # (if known):_____

Name of Insurance Carrier: _____

Agent/Adjuster: _____

Phone Number: (___)____-_____ Fax Number: (___)____-_____

Policy # (if known): _____ Claim Number: _____

DESCRIPTION OF AT-FAULT PARTY'S VEHICLE

Car Make and Model: _____Plate Number: _____

Owner's Name, if different from driver: _____

Were there passengers in the other driver's vehicle? Yes ____ No____

If yes, how many? _____

Were there independent witnesses (individuals who were **not involved** in the accident who saw what happened?) Yes ____ No____

PROPERTY DAMAGETO YOUR VEHICLE

IS YOUR VEHICLE DRIVABLE? Yes/ No Estimated Damage: $_____

WHERE IS YOUR VEHICLE LOCATED? _____

Your vehicle's year, make, model and color: _____

Your vehicle's plate number: _____

Do you have a clear title on your vehicle? Yes ____ No____

Who is the owner of your vehicle? _____

PLEASE NOTE: IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE

Can you supply us with pictures of your vehicle? Yes ____ No____

IF NOT, is your vehicle available for us to take pictures? Yes ____ No____

If yes, where is it located: _____

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto insurance carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: (___)____-_____ Fax Number: (___)____-_____

Claim Number (if known): _____

Type of Coverage: _____ Limit: $_____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No____

If yes, please state, to whom given and when: _____

_____

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail: _____

_____

_____

Did you go to the Hospital? Yes ____ No____ _____
Name of Hospital

Transported by Ambulance? Yes ____ No____ _____
Name of Ambulance Service

X-rays/imaging? Yes ____ No____

HAVE YOU SEEN A DOCTOR OR CLINIC SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No____

If yes, please list all Medical Provider's name/address/number:

_____
Name Address Phone Number

_____
Name Address Phone Number

_____
Name Address Phone Number

_____
Name Address Phone Number

LOSS OF EARNINGS

IF YOU WILL HAVE LOSS OF EARNINGS DUE TO THIS ACCIDENT:

Employer: _____

Your position or title: _____

Rate of pay: $_____ per hour OR $_____yearly salary

How many hours do you normally work per week?_____

HEALTH INSURANCE

DO YOU HAVE HEALTH INSURANCE? IF YES, COMPLETE THE FOLLOWING:

Name of insurance carrier: _____

PO, HMO, Medicaid, other (please circle one)

Name of Policy Holder: _____

Policy Number: _____

PRIOR ACCIDENTS, ON THE JOB INJURIES, OR OTHER INCIDENTS WHEREIN YOU WERE INJURED(Please DO NOT leave blank, if none, so state)

Please include DATE, NATURE OF ACCIDENT OR INCIDENT AND INJURIES and specify if auto, work related, slip & fall, medical negligence, etc.

_____

_____

_____

_____

_____

_____ _____

Date Signature