Figeroux & Associates

Auto Accident - Client Intake Sheet

Critical Deadlines:
City/Public Authority Involved? Yes[ ] No[ ]
Type:
NOC Deadline: **File#**
SOL: **Referred by:**
Referred Phone #:
Address:
Relation to Client:

Client Name:

Address:

City: **State:** **Zip:**

Date of Birth: **SS#**

Telephone#: **Cell#:** **Job#:**

Spouse or Guardian Name:

Email Address:

Children Information

Name	Address	Birth Cert.	Date of Birth

Employer:

Address:

City: **State:** **Zip:**

Occupation:

Weekly/Biweekly Salary: **Date Employment Commenced:**

No. of Hours Worked Per Day: **No. of Day Worked Per Week:**

Supervisor: **Phone No.:**

Last Day Worked Before Accident:

Date Returned: **Light/Restricted Duty?:**

How Long Were You Confined To Bed: **How Long Were You Confined Home:**

Employer's Disability Carrier:

Address of Employer's Disability Carrier:

City: **State:** **Zip:**

Disability Carrier's Policy No.:

Workers Compensation Carrier:

Address of Workers Compensation Carrier:

City: **State:** **Zip:**

WCB Carrier Case No.:

Education: **Grade Level:**

ACCIDENT INFORMATION

Date of Accident: **Day:** **Time:**

Location Of Accident:

City: **State:** **Zip:**

Client Was Traveling On What Street/Road:

PROPERTY DAMAGE

Property Damage Estimate:

Towing Receipts: Yes [ ] No [ ] **Photographs of Vehicle: Yes [ ] No [ ]**

You were coming from? **Going to?**

Offending Vehicle Was Traveling On What Street/Road

Weather: **Plaintiff's Position In Vehicle:**

Accident Description:

Precinct: **Accident No.:**

Officer's Name: **Officer's Badge No.:**

Police Report: Yes [ ] No [ ] **Tickets Issued: Yes [ ] No [ ]**

Arrest: Yes [ ] No [ ] **Traffic Control Device: Yes [ ] No [ ]**
Type:

Diagram Of The Accident:

Witnesses:
Witness #1 Name:
Address:

Phone Number:

Witness #2 Name:
Address:

Phone Number:

Witness #3 Name:
Address:

Phone Number:

[ ] Our client was the _____ in vehicle # 1 (Owner/Operator/Passenger).
[ ] Our client was a pedestrian.
Vehicle No. 1: (Host Vehicle)

Vehicle Plate No.: **Vehicle's Year:**
Vehicle's Make: **Vehicle's Model:**
Vehicle's VIN #:
Owner's Name:
Owner's Address:

Leaseholder's Name:
Address:

Operator:
Address:

Carrier/Insurance Code:
Address:
Policy Holder:
Policy No.:
Effective Date of Policy: **Expiration Date of Policy:**

Vehicle No. 2:
Vehicle Plate No.: **Vehicle's Year:**
Vehicle's Make: **Vehicle's Model:**
Vehicle's VIN #:
Owner's Name:
Owner's Address:

Leaseholder's Name:
Address:

Operator:
Address:

Carrier/Insurance Code:
Address:

Policy Holder:
Policy No.:
Effective Date of Policy: **Expiration Date of Policy:**
Dec Sheet:

Vehicle No. 3:
Vehicle Plate No.: **Vehicle's Year:**
Vehicle's Make: **Vehicle's Model:**
Vehicle's VIN #:
Owner's Name:
Owner's Address:

Leaseholder's Name:
Address:

Operator:
Address:

Carrier/Insurance Code:
Address:

Policy Holder:
Policy No.:
Effective Date of Policy: **Expiration Date of Policy:**
Dec Sheet:

Medical Care
Injuries Sustained:
Photographs of Injuries: Yes [ ] No [ ]
Disfigurement/ Scaring: Yes [ ] No [ ]

Emergency Care At Scene?
Ambulance: Yes[ ] No[ ]

Hospitals
Hospital #1:
Date Of Treatment: **Date Of Discharge:**
Address:

Treatment Type: [ ] ER [ ] Admission [ ] Outpatient [ ] Clinic Visit

Hospital #2:
Date Of Treatment: **Date Of Discharge:**
Address:

Treatment Type: [ ] ER [ ] Admission [ ] Outpatient [ ] Clinic Visit
Dec Sheet:

Physicians

1. Doctor's Name: **Specialty:**
Address:

Phone: **First Visit:**

2. Doctor's Name: **Specialty:**
Address:

Phone: **First Visit:**

3. Doctor's Name: **Specialty:**
Address:

Phone: **First Visit:**

Priors

Has The client ever been involved in an automobile accident? Yes[ ] No[ ]
If yes, complete the following:
DOA: **Place:**
Description:

Injuries Sustained:

List the medical providers who rendered treatment:

Did the client commence a lawsuit? Yes [ ] No [ ]
If Yes, Please list the name and address of client's prior counsel: