CARLSON, MEISSNER HART & HAYSLETT, P.A.

The Law Offices of Carlson & Meissner

©

CLIENT INFORMATION AUTOMOBILE ACCIDENT

Date: _____

Attorney: _____

I. Referral Information

How were you referred to our office?

Doctor _____ Attorney _____

Client _____ Other _____

TV ☐ (Brighthouse) ☐ (Verizon Fios)

Yellow Pages (circle correct ad): Hernando County - ☐attorney ad ☐criminal ☐W/C

New Port Richey - ☐attorney ad ☐criminal ☐W/C

Tarpon Springs - ☐attorney ad

Clearwater - ☐attorney ad ☐W/C

St. Petersburg - ☐attorney ad ☐criminal

II. Client Personal Information

First, Middle, Last Name: _____

Address: _____
Street *City* *State* *Zip*

Telephone: Home_____ Work_____ Cell _____

Email Address: _____

I am granting permission for the law firm to forward confidential information to me regarding my case via Email. ☐Yes ☐No

Social Security Number:_____ Sex: _____ Race: _____

Date of Birth: _____ Age: _____ Is injured party a minor? ☐Yes ☐No

If minor, name of parent/guardian:_____

Are you literate in English? ☐Yes ☐No Are you a high school graduate? ☐Yes ☐No

If you are not a high school graduate, GED? ☐Yes ☐No Years of college completed:_____

Are you currently represented by an attorney for any other matter? ☐Yes ☐No If yes, please give the name of the attorney and describe the matter for which you are represented.

_____

_____

_____

Have you ever been involved in a lawsuit? ☐Yes ☐No If yes, please explain the nature, date, county and state of the lawsuit:_____

_____

_____

Married: ☐Yes ☐No If yes, spouse's name: _____

Children (Names/Ages): _____

_____

Have you served in the military? ☐Yes ☐No If yes, in what branch did you serve?_____

Have you ever been convicted of a felony? ☐Yes ☐No If yes, please state the charge, date, county and state of the charge: _____

Please list any social or recreational organizations/clubs in which you are a member: _____

_____

Please list any sports or social activities in which you participate on a regular basis: _____

_____

III. Bankruptcy

Have you ever filed for bankruptcy? ☐Yes ☐No
If yes, please give Date:_____ Place:_____

Do you anticipate the need to file bankruptcy in the foreseeable future? If yes, please explain:

_____

IV. Client Employment Information

Were you employed at the time of the accident? ☐Yes ☐No
If no, please proceed to the next section (Medical Information).
If yes, please complete the following:

Employer: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Job Title/Description: _____

Salary: $_____ hourly/weekly/monthly/yearly

Have you missed any time from work because of the injuries you suffered in the accident or do you anticipate missing time from work in the future? ☐Yes ☐No
If no, please proceed to the next section (Medical Information)
If yes, please complete the following:

Employment start date: _____Date you were terminated, if applicable:_____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? ☐Yes ☐No
If you are still unable to work because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) $_____

Did you file a Federal Income Tax Return for each year during the five years preceding this accident? ☐Yes ☐No

Employment History

What other types of positions/jobs have you held in the past? _____
_____

Previous employers, dates of employment, salary: _____
_____
_____

Were you working a second job at the time of the accident? ☐Yes ☐No
If no, please proceed to the next section (Medical Information).
If yes, please complete the following:

Second Employer: _____

Address: _____
Street *City* *State* *Zip*
Phone: _____ Job Title/Description: _____

Second job salary: $_____ hourly/weekly/monthly/yearly

Employment start date:_____Date you were terminated, if applicable:_____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? ☐Yes ☐No

If you are still unable to work your second job because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) $_____

V. Medical Information

Injuries/Conditions (Current and Past)

Description of injuries: _____
_____

Were you hospitalized? ☐Yes ☐No
If yes, how many days? _____

Have you had any significant medical problems in the past? ☐Yes ☐No If yes, please explain: _____
_____

Please check which of the following complaints/symptoms you experienced *prior* to this accident and whether you treated with a physician for the complaints:

Condition	*Treated with Physician*	*Physician Name, City, State*
neck pain	☐ Yes ☐ No	_____
back pain	☐ Yes ☐ No	_____
jaw pain	☐ Yes ☐ No	_____
headaches	☐ Yes ☐ No	_____
shoulder pain	☐ Yes ☐ No	_____
hip pain	☐ Yes ☐ No	_____
arthritis	☐ Yes ☐ No	_____
fibromyalgia	☐ Yes ☐ No	_____

Have you previously been injured in an automobile accident, work-related accident, fall or any other type of accident? Yes No If yes, please provide the following information:

Date of Accident Type of Accident City/State Injuries
_____
_____
_____

Has a physician placed you at "maximum medical improvement? (MMI) for the injuries suffered in this accident? Yes No Unknown If yes, name of physician: _____ Any percentage of impairment, if known: _____%

Please list any restrictions which your physician has imposed because of your injuries (i.e. lifting, bending, etc): _____
_____

Loss of Consortium: ☐Yes ☐No

Do you have photographs depicting your injuries? ☐**Yes**☐**No**

Health insurance coverage

Primary insurance company: _____
Address:_____
Telephone:_____ Policy No.: _____
Secondary insurance company:_____
Address:_____
Telephone:_____ Policy No.: _____

Medicare Information:

Are you eligible for Medicare?: ☐Yes ☐No
Have bills been submitted to Medicare for payment?: ☐Yes ☐No

Has Medicare paid any bills?: ☐Yes ☐No; Amount Paid: $_____
Do you expect to be eligible for Medicare in the next 36 months? ☐Yes ☐No

Medicaid Information:

Are you eligible for Medicaid?: ☐Yes ☐No
Have bills been submitted to Medicaid for payment?: ☐Yes ☐No
Has Medicaid paid any bills?: ☐Yes ☐No; Amount Paid: $_____

Social Service Information:

Has any Social Service Agency provided support or paid any bills for you with regard to this incident?:
☐Yes ☐No
If yes, please identify the agency: _____

Short and/or Long Term Disability Information:

Do you have a Short Term Disability policy in effect?: ☐Yes ☐No
Insurance Company: _____; Policy No.: _____
Have any benefits been paid?: ☐Yes ☐No; Amount Paid: $_____

Do you have a Long Term Disability policy in effect?: ☐Yes ☐No
Insurance Company: _____; Policy No.: _____
Have any benefits been paid?: ☐Yes ☐No; Amount Paid: $_____

Social Security Information:

Are you collecting Social Security Disability?: ☐Yes ☐No
Benefit Paid $_____, per month since _____.

Have you applied for Social Security Disability?: ☐Yes ☐No
Date of Application: _____; Denial received _____;
Who made the application for you?: _____.

Medical treatment (Current and Past)

Please list below the name, city and state of all medical providers who have treated or examined you relative to your injuries:

Ambulance: _____

Hospital – Emergency Room only: _____

Hospital – Admitted: _____

Primary treating physician: _____

Chiropractor: _____

*Orthopedist:*_____

*Neurologist:*_____

Neurosurgeon: _____

*Physiatrist (Physical Medicine/Rehabilitation):*_____

*Physical Therapy Facilities:*_____

*MRI/Diagnostic Testing Centers:*_____

*Other:*_____

Have you ever treated with a chiropractor *prior to* this accident ? ☐Yes ☐No Is yes, please provide the date of treatment, and name and address of chiropractor:
_____
_____

Please provide the name, city and state of all physicians with whom you have consulted AND all hospitals where you have been treated, **other than for this accident, within the past ten (10) years:**
_____
_____
_____
_____
_____
_____

VI. Automobile Accident Information

Date of Accident:_____ Time:_____ AM/PM

How did the accident happen? _____
_____
_____
_____

How did your injuries occur (i.e. did you strike the dashboard/steering wheel/windshield with any part of your body? were you thrown forward? did your seat snap backwards? were you thrown from the vehicle?):_____
_____

Location of accident (street/intersection):_____

City of accident:_____ County: _____

Did the police respond to the scene? ☐ Yes ☐ No What agency? _____

Were any citations issued? ☐ Yes ☐ No If yes, who was cited? what charge? _____
_____

Were you wearing a seatbelt? ☐ Yes ☐ No Was a seatbelt available? ☐ Yes ☐ No

Were you driver/passenger? Did you own the vehicle in which you were riding? ☐ Yes ☐ No
If no, provide the name of the vehicle owner: _____

Was the vehicle in which you were riding damaged? ☐ Yes ☐ No If yes, what is the amount of damage? $_____

Did you take a blood alcohol test? ☐ Yes ☐ No If yes, BAC level: _____

List the names/addresses of all persons riding in the vehicle with you: _____
_____

Name/address of *driver* of the at-fault vehicle:_____
_____

Name/address of *owner* of the at-fault vehicle (if different from driver):_____
_____

Did the driver of the at-fault vehicle take a blood alcohol test? ☐ Yes ☐ No Unknown

Eyewitnesses to accident: _____
_____

Other potential defendants:_____

Were any photographs taken at the scene? ☐ Yes ☐ No If yes, by whom? _____

Do you have photographs depicting the damage to your vehicle? ☐ Yes ☐ No

VII. Automobile Insurance Information

Have you been involved in any automobile accident prior to/subsequent to this accident?
☐ Yes ☐ No If yes, please provide the date, city and state of the accident(s):
_____
_____

Prior to this accident, had you made any claims under any automobile insurance policy?
☐ Yes ☐ No
If yes, please provide the reason for the claim (i.e. property damage, personal injury) and the date the claim was made: _____
_____

Client's automobile insurance coverage

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage: PIP ☐ Yes ☐ No Deductible:_____
Medical Payments ☐ Yes ☐ No Limits:_____
UM/UIM ☐ Yes ☐ No Limits:_____
Stacking/Non-stacking

Please list below all occupants of your home (over 16 years old) on the date of the accident, their relationship to you and ownership of any vehicles:

Name *Relationship* *Vehicle Owned* *Insurance Company*

_____
_____
_____

Additional vehicles owned by you:

_____
_____
_____

Your Umbrella Insurance:

Do you have Umbrella insurance coverage?: ☐ Yes ☐ No; Amount: $_____
Insurance Company: _____; Policy No.: _____

If you were a passenger in a vehicle, please provide the insurance information for the owner of the vehicle in which you were riding

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage: PIP ☐ Yes ☐ No Deductible:_____
Medical Payments ☐ Yes ☐ No Limits:_____
UM/UIM ☐ Yes ☐ No Limits:_____

Information concerning the *driver* of the at-fault vehicle

Driver's name: _____

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage: Bodily Injury Liability (BI) ☐ Yes ☐ No Unknown Limits:_____

Information concerning the *owner* of the at-fault vehicle (if different from driver)

Owner's name:_____

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage: Bodily Injury Liability (BI) ☐ Yes ☐ No Unknown Limits:_____

VIII. Additional Information/Comments

_____
_____
_____
_____
_____
_____
_____
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