INCIDENT INFORMATION SHEET

CLIENT INFORMATION Date_____

Client Name: _____ Driver or Passenger? (please circle)
Mr. Ms. or Mrs.
Spouse's full name, if married: _____

_____
Address City State/Zip Code

Home # _____ Work # _____ Cell # _____

E-Mail at home _____ E-Mail at work _____

Date of Birth _____ Social Security # _____Driver's License _____

Emergency Contact: Name: _____ Address: _____

Home # _____ Work# _____Cell# _____Email: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:
Father: _____ Telephone: _____
Mother: _____ Telephone: _____

ACCIDENT INFORMATION

Date of Incident: _____ Time of Incident:_____ AM or PM?
City of Incident: _____ County of Incident: _____
Road/Intersection (if applicable)
_____

WERE THE POLICE CALLED TO THE SCENE? Yes ____ No___
WAS AN ACCIDENT OR INCIDENT REPORT FILED? Yes ____ No___
If the Police DID NOT file an Accident Report, did you file a Blue Form? Yes ____ No ___

If yes, please state the accident or incident report number: _____
Passenger in car accident? Please give driver's full name: _____

UNDERSTANDNG OF HOW THE INCIDENT OCCURRED: _____

_____

_____

_____

_____

_____

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

NAME _____ Contact Number: _____

_____

Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

Driver's License: _____ Spouse's Name, if Married:_____

INJURIES: _____

Did above go to the hospital? Yes ____ No _____ _____

Name of hospital

Transported by ambulance? Yes ____ No _____ _____

Name of ambulance service

Did they take x-rays? Yes_____ No _____

IS ABOVE SEEING A DOCTOR NOW? Yes ____ No _____ (list all Dr.'s name/address/number)

_____

_____

Do you anticipate any loss of earnings, due to accident related injuries? Yes _____ No _____

PASSENGERS/COMPANIONS (if applicable): continued

NAME _____ Contact Number: _____

_____

Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

Driver's License: _____Spouse's Name, if Married: _____

INJURIES: _____

Did above go to the hospital? Yes ____ No _____ _____

Name of hospital

Transported by ambulance? Yes ____ No _____ _____

Name of ambulance service

Did they take x-rays? Yes____ No_____

IS ABOVE SEEING A DOCTOR NOW? Yes ____ No _____ (list all Dr.'s name/address/number)

_____

_____

Do you anticipate any loss of earnings, due to accident related injuries? Yes _____ No _____

IF APPLICABLE: PROPERTY DAMAGE
(Damage to your vehicle)

DO YOU NEED HELP IN RESOLVING THE DAMAGE TO YOUR VEHICLE? Yes ____ No ____
(There is NO fee for this service, unless the payment of the property damage in your case is contested)

IS YOUR VEHICLE DRIVABLE? Yes ___ No ___

Estimated Damage: $_____

WHERE IS YOUR VEHICLE LOCATED? _____

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

Your vehicle plate number: _____

Do your have clear title to your vehicle? Yes ____ No____

Who is the owner of your vehicle? _____

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

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 APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: _____

Claim Number (if known): _____

Type of Coverage: _____ PIP Limits: $ _____

DEFENDANT INFORMATION: IF APPLICABLE
AUTOMOBILE INSURANCE

Driver's Name: _____ Telephone Number: _____

Address: _____

_____ _____
Driver's Date of Birth, if known Driver's license number, if known

Name of Insurance Carrier: _____

Agent/Adjuster: _____

Telephone Number: _____ Fax Number: _____

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

DESCRIPTION OF DEFENDANT'S (other driver) VEHICLE:

Year, 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 ___

Please list the following with respect to any independent witnesses:

Name: _____ Phone Number: _____

Address:_____

Name: _____ Phone Number:_____

Address:_____

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

Did you go by ambulance? Yes ____ No____ _____
Name of Ambulance Service

Did they take x-rays? Yes _____ No _____

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No ____

If yes, please list all Doctors: name, address and telephone number

_____

_____

B&G REFERRED TO: _____
(for office use only)

LOSS OF EARNINGS

IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING:

Employer: _____

Your position or title: _____

Rate of Pay: $ _____ per hour or $ _____ yearly salary

How many hours do you normally work per week? _____

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

Name of Insurance Carrier: _____

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

Name of Policy Holder: _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No ____

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

_____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS
(**Please DO NOT leave blank, if none, so state)**

DATE NATURE OF ACCIDENT OR INCIDENT INJURIES
(auto, work related, slip & fall, medical negligence?)

_____

_____

How were you referred to us? (Circle one) I am a previous client Office sign Web Site

Phonebook: name of book_____Other _____
(please describe how you came to Bailey & Galyen today)

Name of person who referred you: _____
their address: _____
their telephone: _____

DO YOU CURRENTLY HAVE A WILL? Yes _____ No _____
HAVE YOU BEEN DENIED SOCIAL SECURITY BENEFITS? Yes _____ No_____
HAVE YOU BEEN DENIED VETERANS BENEFITS? Yes _____ No_____
DO YOU HAVE NEED LEGAL ASSISTANCE IN AN IMMIGRATION MATTER? Yes____ No_____

FOR OFFICE USE ONLY

INTERVIEWER: _____

OFFICE LOCATION: _____

HOME VISIT/DOCTOR'S OFFICE: _____

DATE OF VISIT: _____

DID THE CLIENT RETAIN Yes _____ No _____

IF APPLICABLE: WRONGFUL DEATH INFORMATION SHEET

Client(s) relationship to Decedent: _____

Decedent's Name: _____

_____
Address City State/Zip Code

Decedent's:
Date of Birth _____ Social Security # _____ Driver's License # _____

Decedent's Employer: _____

_____
Address City State/Zip Code

Job Title/Description: _____

Salary wage rate: _____ Length of Time @ employment _____

Education: High School: Yes ___ No ___ Graduated: Yes ___ No ___; College: Yes __ No ___ Degree: Yes ___ No ____Post Graduate Yes ____ No _____ Degree: Yes _____ No _____
Other (Please List): _____

WAS DECEDENT MARRIED: _____ YES ____ NO

NAME OF SPOUSE: _____

CHILDREN: YES ____ NO ____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

IF APPLICABLE: PRODUCT LIABILITY

PRODUCT COMPLAINED OF: _____

FROM WHAT ENTITY WAS THE PRODUCT PURCHASED: _____

PLACE OF PURCHASE:_____

DATE THE PRODUCT WAS PURCHASED: _____

WHO PURCHASED THE PRODUCT: NAME: _____

ADDRESS: _____ PHONE # _____

ARE THERE PURCHASE/TRANSACTION DOCUMENTS: YES _____ NO _____

IF YES, CAN YOU SUPPLY: YES ____ NO ____

PRODUCT SPECIFIC INFORMATION:

MANUFACTURER: _____

MODEL NUMBER: _____

SERIAL NUMBER: _____

ARE THERE INSTRUCTION SHEETS, LIMITED WARRANTIES AND/OR OWNER MANUALS FOR THE PRODUCT COMPLAINED OF: YES ____ NO ____

CAN YOU SUPPLY US WITH THIS INFORMATION: YES ____ NO ____