Client Intake Form

Wrongful Death

Today's Date: ____

First Name: __________________ Middle Name ______________ Last Name: ____________________

Address: ____ City: ____________ State: ________

Home Phone: ____________________Cell Phone: _________________Work Phone:_______________

Email Address: ____

Date of Birth: __________________________ SSN:____

Married ___ Single ___ Divorced ___ Widowed ___ Minor ___

Spouse's Name: ____

Spouse's Date of Birth: ___________________ Spouse's SSN:__________________________________

ACCIDENT DETAILS

Date of Accident: ___________________________________ Time of Accident: ___________________

Location of accident? ____

City: ____ State: _____________________________

Other involved persons or entities, including opposing parties: __________________________________

____

Did police arrive at the location of the accident? Yes _____ No _____

If yes, what police department? __________________________ Report No.: ______________________

Describe in detail how this accident happened: ____

____

____

____

____

____

____

____

____

Please draw a diagram of the accident scene:

Did you talk to any witnesses at the scene of the accident? Yes _____ No _____

If yes, please list any and all witnesses:

Name: ________________ Relation to you: _______ Address: _________________ Phone #: _________

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Name: ________________ Relation to you: _______ Address: _________________ Phone #: _________

Did you report this accident to any insurance agent or company? Yes _____ No _____

Did you give a statement to any insurance company? Yes _____ No _____

If yes, when and what insurance company? ____

Please list any claim numbers you have been given by any insurance carrier for this accident:

Your insurance carrier claim number: ____

Adverse insurance carrier claim number: ____

INJURIES AND TREATMENT

What were the injuries? ____

____

Did victim/deceased go to the hospital? Yes _____ No _____ If yes, how did he/she get to the hospital?

____

At what hospital did he/she get treated? ____

Address: ____

Please list all other providers who provided treatment to deceased as a result of this accident (hospitals, rehabilitation centers, specialists)?

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Did he/she have x-rays, MRI or other diagnostic tests? Yes _____ No _____

Do you know approximate amount of medical bills due to this accident? Amount: $ _________________

Did the victim/deceased have health insurance? Yes _____ No _____ Carrier: ______________________

Please list any other expenses incurred by death (e.g. funeral and burial) ___________________________

____

LOST INCOME OR WAGES

Was victim/deceased working or going to school prior to death? Yes _____ No _____

List school/place of employment: ____

What was his/her job title/degree being sought? ____

Was victim/deceased entitled to benefits prior to death? Yes _____ No _____

If yes, what benefits (i.e. medical, pension, 401K)? ____

How much income and services have already been lost as a result of the death? _____________________

____

How much income and services are reasonably probable to be lost in the future as a result of death? ____

____

ADDITIONAL INFORMATION

Where was the victim/deceased living/residing prior to his/her death? ______________________________

Who was living with victim/deceased prior to his/her death? _____________________________________

Have you or are you filing for bankruptcy? Yes: _____ No: _____

Are you paying child support? Yes: _____ No: _____

Do you currently or have you had another attorney in this matter? Yes _____ No _____

If yes, who is/was your other attorney? ____

Emergency contact information:

Please provide two names and phone numbers of close relatives that do not live with you:

Name: _________________________ Phone Number: ____________________ Relation: ____________

Name: _________________________ Phone Number: ____________________ Relation: ____________

How did you hear about us? ____

I___________________________ understand that this is a **free consultation** about my accident and that I am not represented until I speak with the attorney who agrees to accept my case and I sign a fee agreement. I understand that my case may or may not be accepted by the attorney.

Sign Name: ____________________________ Date: ____

Print Name: ___________________________ Date: ____