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Date: ____________________

## PERSONAL INJURY INTAKE FORM

Name: ____________________ Date of Birth: ______________ Age: _______

SSN: __________ Sex: ☐ Male ☐ Female DLN: ____________________

Present Address: ____________________ City: ____________________

State: __________ Zip: __________ Years at Present Address: __________

Phone Number: __________ Email Address: ____________________

Alternative Phone Number/Contact Method: ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated Race: __________

Education Level: ________________ Professional Licenses: ________________

Date of Accident: ____________ Police Agency Investigating: ________________

Accident Report Generated?: ☐ Yes ☐ No If yes, do you have a copy?: ☐ Yes ☐ No

Date of Accident: ______________________ Location of Accident: ______________________

Place of Employment: ______________________ Address: ______________________

List All Injuries Sustained in Accident: ______________________

Did you have any of these injuries prior to the accident? ______________________

Please list all doctors, hospitals, or health care providers you have seen in the last 10 years:

| Name: | Address: | Reason for Treatment: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Did you miss work due to the accident? ☐ Yes ☐ No Number of Days: ______________________

Name of Auto Insurance Co: ______________________

Contact Info for Insurance: ______________________

Are you on Medicaid/care: ☐ Yes ☐ No Still Treating: ☐ Yes ☐ No

How were you referred to our office ?:

☐ Google ☐ Bing ☐ Facebook ☐ AVVO ☐ FindLaw ☐ Newspaper ☐ Radio

☐ Friend/Family: ______________________ ☐ Lawyer: ______________________

☐ Other: ______________________________________________

Attorney Notes:

|  |
|---|
|  |

Statute of Limitations: ______________________________________

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