INTAKE SHEET

DATE OF ACCIDENT: ____________

Today's Date: ____________ Referral Source: ______________________________

BACKGROUND INFORMATION

Full Name: ____
First Middle Last

Other names known by (alias and maiden names):
__________________________________ Email Address: ____________________

Address: ____

City, State, Zip: ____

Telephone: Home: ___________ Office: ______________ Other/Cell: ______________

Date of Birth: ___________________ Social Security No.: _______/_______/_______

Place of Birth: ____

Age: _________ Weight: ____________ Height: ________________

Driver's License No. (including State): ______________________________

Marital Status (Check One): ____ Married ____ Single ____ Divorced
____ Separated ____ Widowed/Widower

Spouse's Name: ____
First Middle Last

Former Spouses: Yes ____ No ____
If yes, list names, addresses, phone numbers and dates of marriage and divorce:

____

____

Children and/or other licensed household drivers (if not child, state relationship):

______________________________ ______________________________
Name Age Name Age

______________________________ ______________________________
Name Age Name Age

OCCUPATION

Employer: ____

Address: ____

Job Title: ____________________ How long employed? ____________________

Name of Supervisor: ____________________ Telephone: ____________________

Last date worked before illness/injury:

____

Rate of Pay: __________ Per: Month _______ Week _______ Bimonthly _______

Date returned to work: ____

Did your job duties change after illness/injury? If yes, indicate how:

____

____

____

Do you have income tax records for the last 5 years documenting your earnings for those years?

Yes ____ No ____

INCIDENT INFORMATION

Date of Accident: ______________ Time: ______________ SOL: ______________

Location: ______________________ County: ________ City: ______________

Weather Conditions: ____

Status: (e.g., driver, passenger, pedestrian, guest, customer, etc.); If passenger, who is driver?___

____

Were police called? Yes ____ No ____ Agency (City Police, County Sheriff, State Trooper): __

____

Was fire department called? Yes ____ No ____

Was ambulance called? Yes ____ No ____ Were you taken to hospital via ambulance? _______

List any citations given and to whom: ______________________________

Do you have copy of accident/incident report?: Yes ____ No ____

Describe what happened: ____

____

____

____

____

Operation/Available Seatbelts? Yes☐ No☐ Seatbelts in use? Yes☐ No☐

Draw a diagram of accident scene:

Did you sign any papers for any insurance companies or give any verbal or written statements to any insurance companies? If so, please state to whom given: ______________________

Were any statements made by the other parties accepting fault for this accident? Yes __ No__

If yes, state the content of this statement and to whom it was made:

____

____

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your automobile insurance company: ____________________

Address: ____________________

Policyholder/Insured (If not you): ____________________

Policy Number: ____________________ Claim Number: ____________________

Adjuster's Name: ____________________ Phone Number: ____________________

Policy Limits: ____________________ PIP application completed? Yes ____ No ____

If you were either driving or a passenger in a vehicle not owned by you, please answer the following:

Name of vehicle owner: ____________________

Address of vehicle owner: ____________________

Vehicle owner's automobile insurance company: ____________________

Address of owner's automobile insurance company: ____________________

____

Telephone No.: ____________________ Policy No.: ____________________

Claim No.: ____________________ Adjuster's Name: ____________________

DESCRIPTION OF VEHICLE INVOLVED IN CRASH

Vehicle (Year/Make/Model): ____________________

Plate Number (include State): ____________________

Describe damage to your vehicle: ____________________

Location of your vehicle: ____________________

Property damage resolved? Yes ____ No ____ Do you have a copy of the repair estimate? ____

Were Photographs taken? Yes ____ No ____ If so, by whom? ____________________

Please state location of damaged vehicle: ____________________

Have you reported the crash to your insurance company? Yes ___ No ____

WORKER'S COMPENSATION

Were you on the job at the time of the accident? Yes ____ No ____

Workers' Compensation carrier: ____

Address: ____

Insured: ______________________ Claim Number: ______________________

Adjuster's Name: ____________________ Phone Number: ____________________

Are you collecting any Worker's Compensation benefits because of your injuries related to this accident? Yes __________ No __________

HEALTH INSURANCE INFORMATION

Please list information on ALL health insurance policies available to you from the date of the accident until today, including group or individual, Medicare, Medicaid (all companies from which you get Medicaid benefits) and all supplemental health insurance policies covering you. If you have been covered (since the date of the accident) by more than three health insurance companies, please use the back of this form to write the additional information.

A. If you have had no health insurance coverage (from the date of the accident until today), please put "none" on line 1.

B. If you have Medicaid, please put WHY you qualify for this and list all Medicaid companies that you collect benefits from such as Florida Medicaid, Wellcare, Staywell, Medi Pass, Healthease, Amerigroup, United Health Care of Florida, etc. We need copies of <u>all</u> of the insurance cards from all of the companies you collect Medicaid benefits from.

C. If you have Medicare AND ARE NOT 65 YEARS OLD, please put WHY you qualify for this.

PLEASE PROVIDE US WITH A COPY OF ALL HEALTH INSURANCE CARDS. If you do not have all of your health insurance cards with you today, please bring the cards to our office so that photo copies can be made for our file.

(1) ____

Address: ____

Policyholder: ____________________ ID/Policy Number: ____________________

If Group Plan, employer of policyholder: ______________________________

(2) ____

Address: ____

Policyholder: ______________________ ID/Policy Number: ________________________

If Group Plan, employer of policyholder: ____

(3) ____

Address: ____

Policyholder: ______________________ ID/Policy Number: ________________________

If Group Plan, employer of policyholder: ____

DISABILITY

Are you on Social Security Disability? Yes _________ No _________

If yes, do you get monthly benefits? Yes _________ No _________

AT-FAULT PARTY INFORMATION

Name: ____

Address: ____

Driver's License No. (include State): ____

Vehicle: ___________________________ Plate Number: __________________________

Insurance Company: ______________________ Adjuster's Name: ___________________

Policy Number: ____________________ Claim Number: ___________________________

Policy Limits: ______________________ Recorded statement given? Yes ____ No ____

Was there more than one at-fault party? If so, list immediately below

Name: ____

Address: ____

Driver's License No. (include State): ____

Vehicle: ___________________________ Plate Number: __________________________

Insurance Company: ______________________ Adjuster's Name: ___________________

Policy Number: ____________________ Claim Number: ___________________________

Policy Limits: ______________________ Recorded statement given? Yes ____ No ____

WITNESS INFORMATION

Names of any witnesses: (Please include addresses and telephone numbers, if known.)

____

Name | Address | Telephone

____

Name | Address | Telephone

INJURIES/MEDICAL TREATMENT

List all **PAIN** and **SYMPTOMS** you have felt from this accident (from your head to your toes):

____

____

____

Have you sustained any visible bruises and/or scarring as a result of the accident?
YES _____ NO _____

List ALL health care providers you have treated with for this accident including ambulance, hospital, treating doctors, family doctors, chiropractors, neurologists, orthopaedists, MRI testing, physical therapy, massage therapy, CT scans, X-rays, etc.

Were you transported by ambulance? Yes _____ No _____

Name of Ambulance Company: ____

Name of hospital where you were initially treated: ______________________________

Have you had any additional visits to any hospital for ER treatment or for outpatient testing?

Yes _____ No _____ Dates: ____

In sequential order, if possible, list all other health care providers you have treated with for this accident: ____

____

____

____

____

When are your next doctors' appointments?

Dr. Name: ______________________________ Date: __________________________________

Dr. Name: ______________________________ Date: __________________________________

PRIOR INJURIES AND MEDICAL TREATMENT

Describe in detail each and every **PAST** injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.) even if you sustained no injury and/or made no claim.

Motor vehicle accidents: ____

____

Slip and fall/trip and fall accidents: ____

____

Injuries that occur on the job: ____

____

School and/or sport-related injuries: ____

____

Other injuries or complaints: ____

____

Name and address of family physician and/or primary care physician: ____________________

____

Have you ever complained to or treated with any of the following **PRIOR TO** this accident?

1. Chiropractor: Yes _____ No ____ If so, with whom? ____________________
2. MRI facility: Yes _____ No ____ If so, where? ________________________
3. Orthopaedist: Yes _____ No ____ If so, with whom? ____________________
4. Other: ____

List every surgery you have had to date:

____

____

ADDITIONAL BACKGROUND INFORMATION

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons and results.

____

____

Have you ever been arrested? Yes ____ No ____

If yes, please provide the following information:

Date: ____________________ Charge: ______________________________

Have you ever been convicted of a crime? Yes ____ No ____

If yes, please provide the following information:

Date: ____________________ Charge: ______________________________

Date: ____________________ Charge: ______________________________

Result (fine, penalty, probation, confinement, etc.): ______________________________

____

Do you currently have a bankruptcy case pending? Yes ________ No ________

If yes, please list the name and address of your bankruptcy attorney.

____

Have you ever filed bankruptcy? Yes _________ No _________

If yes, please provide the following information:

Date: ____________________ Location: ______________________________

PLEASE NOTE THAT THE FILING OF BANKRUPTCY DURING THE PENDENCY OF YOUR ACCIDENT CLAIM MAY ADVERSELY AFFECT YOUR CASE!

Have you ever been represented by any other attorney for any reason? Yes ____ No ____

Name: ____

Address: ____

Reason: ____

Give the names, addresses and telephone numbers of two people who will always know where to reach you:

____
Name Address Phone

____
Name Address Phone

tb/11/15/12