

The SOUD Law Firm  
**New Client Information/Case Information**  
(Auto Accident Intake Form 2019)

DATE OF INITIAL CONFERENCE: \_\_\_\_\_ INTAKE LOCATION: \_\_\_\_\_ BY: \_\_\_\_\_

OFFICE FILE NUMBER: \_\_\_\_\_ COURT/COUNTY: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

ALL INFORMATION IS CONFIDENTIAL INCLUDING PHONE NUMBERS & E-MAILS AND WILL REMAIN IN THIS OFFICE

**WHO WAS HURT:** LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M: \_\_\_\_\_

[ IF THE PERSON WAS A MINOR, WHO IS THE PARENT / GUARDIAN: \_\_\_\_\_ ? ]

CELL: \_\_\_\_\_ HOME PH: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

**EMPLOYMENT:** WHERE DO YOU WORK? \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PH: \_\_\_\_\_ WORK E-MAIL: \_\_\_\_\_

**MARITAL STATUS:** MARRIED  / SINGLE  / DIVORCED  / WIDOW(ER)  / DOMESTIC PARTNER

SPOUSE'S / PARTNER'S NAME: \_\_\_\_\_ / CELL: \_\_\_\_\_

EMPLOYER FOR SPOUSE: \_\_\_\_\_ SPOUSE WORK PH: \_\_\_\_\_

SPOUSE'S / PARTNER'S E-MAIL: \_\_\_\_\_

CHILDREN: HOW MANY CHILDREN DO YOU HAVE? \_\_\_\_\_. HOW MANY KIDS UNDER THE AGE OF 18? \_\_\_\_\_.

WHAT ARE THE NAMES OF THE CHILDREN WHO LIVE WITH YOU AT HOME, REGARDLESS OF AGE?

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**EMERGENCY CONTACT:** (SOMEONE NOT LIVING WITH YOU): \_\_\_\_\_

WHO ARE THEY: (RELATIONSHIP): \_\_\_\_\_ / CELL: \_\_\_\_\_

HOME PH: \_\_\_\_\_ / WORK PH: \_\_\_\_\_ / EMAIL: \_\_\_\_\_

WHERE DO THEY LIVE (CITY / STATE): \_\_\_\_\_

**ACCIDENT DETAILS:** DATE & TIME: \_\_\_\_\_ (STATUTE OF LIMITATIONS: \_\_\_\_\_)

PURPOSE OF YOUR TRIP: \_\_\_\_\_

LAW ENFORCEMENT ACCIDENT REPORT NO.: \_\_\_\_\_ (JSO  OR FHP  OR OTHER )

**YOUR INSURANCE:** YOUR PERSONAL VEHICLE: YR: \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_

YOUR INSURANCE COMPANY: \_\_\_\_\_ AND POLICY/CLAIM NO: \_\_\_\_\_.

YOUR COVERAGE: PERSONAL INJURY PROTECTION (PIP): Y  N  / UM (UNINSURED MOTORIST): Y  N

“MED PAY”: Y  N  / PROPERTY DAMAGE Y  N  / LIABILITY (BODILY): Y  N

TOWING Y  N  / RENTAL: Y  N  / COMP-COLLISION: Y  N  / UMBRELLA: Y  N

YOUR ADJUSTER’S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

COMPLETE THE PURPLE SECTION IF YOU WERE **NOT** IN YOUR VEHICLE AT THE TIME OF THE ACCIDENT

WHO WAS THE OWNER OF THE VEHICLE YOU WERE IN: \_\_\_\_\_, AND

AS TO THEIR VEHICLE, YR: \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_,

AS TO THEIR INSURANCE COMPANY: \_\_\_\_\_ AND POLICY / CLAIM NO.: \_\_\_\_\_.

**INJURIES:** WERE YOU (OR THE MINOR) WEARING A SEATBELT? LAP & SHOULDER  NONE

TREATING HEALTHCARE PROVIDER # 1: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ / LOCATION: \_\_\_\_\_

INJURY TREATED \_\_\_\_\_

GENERAL DIAGNOSIS: \_\_\_\_\_

PRESCRIPTIONS GIVEN: \_\_\_\_\_

TREATING HEALTHCARE PROVIDER # 2: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ / LOCATION: \_\_\_\_\_

INJURY TREATED \_\_\_\_\_

GENERAL DIAGNOSIS: \_\_\_\_\_

PRESCRIPTIONS GIVEN: \_\_\_\_\_

**WAGES:** IF YOU ANTICIPATE "LOST WAGES", WHAT IS YOUR AVERAGE WEEKLY INCOME: \_\_\_\_\_

DAYS OFF WORK: \_\_\_\_\_ OUT OF POCKET EXPENSE: \_\_\_\_\_

VEHICLE DAMAGE EST. (OF THE VEHICLE YOU WERE IN): \_\_\_\_\_ / PICTURES: Y  N

**AT-FAULT PARTIES:** DRIVER'S NAME: \_\_\_\_\_ OWNER/DRIVER SAME? Y  N

[ IF NOT THE SAME, WHO IS THE OWNER OF THE VEHICLE THAT HIT YOU: \_\_\_\_\_ ]

AT-FAULT VEHICLE: YR: \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_ / DAMAGE EST.: \_\_\_\_\_

AT-FAULT VEHICLE INSURANCE COMPANY: \_\_\_\_\_

POLICY NO.: \_\_\_\_\_ OR, IS THERE A CLAIM NUMBER: \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU KNOW IF THEY HAVE "BI" OR "BODILY INJURY" COVERAGE: Y  N  IF SO, AMOUNT: \_\_\_\_\_

PHOTOGRAPHS OF AT-FAULT VEHICLE: Y  N  WAS THE OTHER DRIVER WAS ON THEIR CELL PHONE AT THE

TIME OF THE ACCIDENT, TEXTING OR TELEPHONE CALL? Y  N  OR DON'T KNOW

**MISCELLANEOUS MATTERS:**

WHO IS YOUR HEALTH INSURANCE COMPANY: \_\_\_\_\_

**DATES AND TYPES OF PRIOR "ACCIDENTS"**

DATE (MO/YR)      TYPE      WHO IS AT FAULT      INJURY (YES/NO)      COUNTY/STATE

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**DATES AND TYPES OF PRIOR "MEDICAL HISTORY"**

DATE (MO/YR)      TYPE      AREAS INJURED      DR.'S TREATING      LAWYER      SETTLED (Y/N)

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**ANY MILITARY SERVICE?** IF SO, BRANCH: \_\_\_\_\_ RANK: \_\_\_\_\_ DATES OF SERVICE: \_\_\_\_\_

**WHAT IS THE LEVEL OF YOUR FORMAL EDUCATION?** [HS, TRADE SCHOOL, CC, BS, BA, ETC.] \_\_\_\_\_

**ANY PAST LEGAL HISTORY:** ARRESTED FOR A CRIME? Y  N  / CONVICTED OF A CRIME? Y  N

**PAST WORK HISTORY** – PLEASE LIST YOUR PAST 4 EMPLOYERS **OR** YOUR EMPLOYMENT FOR PAST 10 YEARS, WHICHEVER OCCURS FIRST:

<u>EMPLOYER'S NAME</u>	<u>FROM/TO</u>	<u>EMPLOYER'S NAME</u>	<u>FROM/TO</u>
1. _____		2. _____	
3. _____		4. _____	

LET'S MAKE SURE WE COVER THE ISSUES YOU WANT TO DISCUSS

IN A PERSONAL INJURY CASE ATTORNEY CLIENT MEETING, WE WILL DISCUSS MEDICAL BILLS, TREATMENT AND THE FINANCIAL ISSUES ASSOCIATE WITH THAT. SOME OF THOSE FINANCIAL ISSUES COULD INCLUDE WAGE LOSS, COLLECTION EFFORTS OR HOW ALL THIS COULD AFFECT YOUR CREDIT.

AS FOR THE ACCIDENT, WE WILL DISCUSS THE DETAILS OF WHAT HAPPENED, INCLUDING WITNESSES, VEHICLE DAMAGE, RENTAL CARS AND THE WAY INSURANCE WORKS. WE'LL DISCUSS A LOT OF OTHER STUFF TOO, BUT JUST TO BE SURE WE COVER EVERYTHING YOU WANT, WHAT ARE THE PRESSING QUESTIONS OR MATTERS YOU ARE HAVING NOW? MAKE A NOTE OF THEM HERE.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_