CLIENT INFORMATION SHEET

DATE: _____

NAME: _____

ADDRESS: _____

PHONE: _____ WORK: _____ EMAIL: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____

NAME & ADDRESS OF EMPLOYER: _____

MARRIED/SINGLE (circle one)

How did you hear about our office? _____

Date of Accident: _____ Make of car you were in: _____
Place & time accident occurred: _____
Other Driver: _____ Make of other car: _____
Officer's Name & Accident Report No:_____
Name & Policy no. of your Auto Insurance: _____
Other Driver's Insurance Info.: _____
Witnesses names & addresses:_____
_____
_____

DESCRIBE HOW THE ACCIDENT OCCURRED: _____
_____
_____
_____
_____

MEDICAL INFORMATION:
Type of injuries: _____
_____
_____
_____

Time missed from work: _____ Hospital/E.R.: _____

Name & Addresses of Doctors seen: _____
_____
_____
_____

Health prior to accident: _____

Your health insurance company and policy no.:_____

Statement given to anyone: YES NO Ambulance: YES NO X-rays taken: YES NO