Submit Form to Turner & Sackett

Print Form

CLIENT INFORMATION REPORT-PERSONAL INJURY

(Confidential)

Clients frequently have a great deal of valuable information concerning how and why their injury occurred and who was at fault. Good lawyers should be aware of this and listen to their clients. Please help me help you by answering all of the following questions in as much detail as you can. Any problem important enough to see a lawyer is important enough to complete this form.

Write clearly, and only on the printed side of these pages. If more writing space is needed, attach other paper, identify each answer by question number, and write on one side of the page only. **If this form is not complete your appointment may be subject to being rescheduled.**

Date: _____

Injured Party: Name :_____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip code: _____

Telephone number: H: (_____)_____

W: (_____)_____

C: (_____)_____ May we text you? Y ☐ N ☐

E-mail address: _____

Social Security No. : _____ _____ _____

Date of Birth :_____ _____

Age: _____

Employer's Name:_____

Address : _____

Telephone: (_____) _____

Due to Section 111 Mandatory Medicare/Medicaid Reporting Requirements:

Are you a Medicaid recipient? YES NO

Are you a Medicare recipient (or will be within the next 30 months)? YES NO

If so, please provide your Medicare/Medicaid number: _____

Emergency Contact Information (Please include the name, relationship, address and phone number)

Name: _____ Relationship ____ _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip code: _____

Telephone number: (_ _)_____

If Minor: Father's Name:_____

Address:_____

Telephone: (_____) _____

Mother's Name:_____

Address:_____

Telephone: (_____) _____

Custody with: Father _____ Mother _____

Other: _____

How were you referred to our office?

Turner & Sackett Website Internet □ Injury Helpline □

Phone book, which one? Yellowbook □ Superpages □

Attorney □ Name: _____ Family member/Friend □ Name _____

Other _____

1. Injury:

Date of Injury:_____

Time of Day: _____

Day of Week:_____

Location:_____

Weather Conditions:_____

ATTORNEY'S USE ONLY
Statute of Limitations _____

_____

2. Person (s) Who Caused Your Injury:

a. Name _____ _____

Address _____

Name and address of Employer (if known) _____ _____

_____

b. Name _____

Address _____

Name and address of Employer (if known) _____

_____

c. Name _____ _____

Address _____

Name and address of Employer (if known) _____

_____

d. Name _____

Address _____

Name and address of Employer (if known) _____

_____

3. Witnesses to Accident:

a. Name _____ _____

Address _____

_____

Telephone Number (_____) _____

b. Name _____

Address _____ _

_____

Telephone Number (_____) _____

c. Name _____ _____

Address _____

_____

Telephone Number (_____) _____

d. Name _____

Address _____

_____

Telephone Number (_____) _____

4. General Description of What Happened:_____

_____

_____

_____

If appropriate, please draw diagram of the scene of the occurrence:

5. Accident Reports: Was Accident Reported?

To Whom? _____

When? _____

List every entity which might have investigated the incident, including local police, sheriff's office, state troopers, insurance company, etc., including name of investigating officer, if known

_____

_____

_____

_____

Were any criminal or other charges filed as a result of the incident? _____

_____

What was the result of the case? _____

_____

_____

6. Were any photographs taken of the scene, vehicles involved, persons injured, product involved, etc.?

_____

_____

If so, please describe what photographs were taken, by whom they were taken, and who has current possession of the photographs. _____

_____

_____

_____

7. Your Insurance: Name of Company _____ _____

Address _____

_____

Name of Agent _____

Any reports to them? _____

When? _____

What was contained in the report? _____

_____

_____

_____

8. History: Single _____ Married _____

Spouse's Name _____

Prior Marriages? _____

Former Spouses' Names _____

_____

How ended: Divorce _____ Date: _____

Annulment _____ Date: _____

Death ____ _____ Date: _____

9. Children:

Name:_____

Age _____ Claimed as Dependent? _____

Address:_____

Telephone No. (_____) _____

Name:_____

Age _____ Claimed as Dependent? _____

Address:_____

Telephone No.: (_____) _____

Name:_____

Age:_____ Claimed as Dependent? _____

Address: _____ _____

Telephone No.: (_____) _____

Name: _____

Age:_____ Claimed as Dependent? _____

Address: _____

Telephone No.: (_____) _____

10. Other Dependents:

Name: _____

Age:_____ Relationship :_____

Address:_____

Telephone No.: (_____) _____

Name: _____

Age:_____ Relationship: _____

Address: _____

Telephone No.: (_____) _____

Name:_____

Age:_____ Relationship: _____

Address: _____

Telephone No.: (_____) _____

11. Your Educational Background and Vocational Training _____

_____

_____

12. Employment: Position _____

Date Employed _____ _____

Rate of Pay _____ _____ Gross _____ Net _____

Dates lost from work because of this injury:

From ____ _____ to _____

Total Amount of Wages Lost _____

Did you receive any short term or long term disability benefits during your time off work? Yes____ No_____

If so, please identify the name and address from which insurance company such benefits were received:

_____

_____

_____

13. Prior Work Record:

a. Name of Employer _____ _____

Address of Employer _____

Dates of Employment _____ _____

Type of Work _____

Wages _____

Reason for Leaving _____

_____

b. Name of Employer _____ _____

Address of Employer _____

Dates of Employment _____ _____

Type of Work _____

Wages _____

Reason for Leaving _____

c. Name of Employer _____

Address of Employer _____

Dates of Employment _____ _____

Type of Work _____

Wages:_____

Reason for Leaving _____

14. Any Damage Other Than Personal Injury (including Car, if a Vehicle Case): _____ _____

_____

_____

_____

15. Medical (This Injury): (PLEASE COMPLETE THE ATTACHED HEALTH CARE PROVIDER INFORMATION SHEET)

Type of Injury (Describe fully the condition) _____ _____

_____

_____

16. Any Insurance or Compensation Benefits Paid?_____ By Whom?_____

For What? _____

Dates _____ Amounts _____ _____

17. If Case Involves Auto Accident, Complete the Following:

Plaintiff (Your) Vehicle Info: Make _____ _____Model _____ Year _____

Color _____ Registered Owner ____ _____

Address _____

_____

Occupation _____

Legal Owner _____ _____ Age_____ _____

Address _____

_____

Automobile Insurance Policy Company _____ _____

Agent _____

Who was driving? Name_____

Age ____ _____ Address _____

_____

Damage to Vehicle _____

Repaired? _____ Date _____ Cost____ _____

Seat Belts Used? _____

18. Defendant Vehicle Info: Make _____ _____Model_____ Year _____

Color _____ Registered Owner ____ _____

Address _____

Occupation _____

Who was driving? Name_____

Age _____ Address _____

_____

Occupation _____

19. Defendant's Insurance (If Known)* Please fill out whether or not the case deals specifically with automobile accidents.

Name of Company ____ _____

Address _____

_____

Name, address, telephone number and employer of adjusters or insurance representative handling file, if known: _____ _____

_____

_____

Any Reports to Them? _____ When (Date)? _____

20. List all accidents in the past ten (10) years causing injury to you: _____ _____

_____

_____

_____

21. List all lawsuits in which you were a party: _____

_____

_____

22. List all hospitalizations for the past ten (10) years:

a. Hospital ____ _____

Date _____ Reason _____

_____

b. Hospital ____ _____

Date _____ Reason _____

_____

c. Hospital ____ _____

Date _____ Reason _____

_____

23. List all **major** illness in life: _____

_____

_____

_____

_____

==========

FOR ATTORNEY'S USE ONLY

Statute of Limitations: _____ _____ Docketed _____

Medical Authorizations signed _____

Additional instructions:_____

_____

_____

Health Care Provider Information Sheet

*** ATTENTION ***

It is the client's responsibility to keep TURNER & SACKETT updated throughout the pendency of the case of any and all medical treatment and related medical bills associated with his/her claim. Any unknown medical bill(s)/liens/subrogations or any medical bill(s)/liens/subrogations provided after the conclusion of the case *WILL BE THE RESPONSIBILITY OF THE CLIENT.*

For Office Use Only:
DOA: _____
Injured Party: _____

Group Health Insurance Carrier: _____
Policy Number: _____
Insured: _____
Primary Care Provider's Name, Address and Phone Number_____
_____

Please complete the information listed below for all physicians, hospitals, chiropractors, dentists, and oral surgeons, or any other medical provider who has treated you due to this accident.

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________