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480 OLIVE ST., SUITE 2
EL CENTRO, CA 92243
TELEPHONE: (760) 352-8463

PLEASE RESPOND TO:
☑ SAN DIEGO OFFICE
☐ EL CENTRO OFFICE

DATE: ______________________________

LEGAL PLAN (IF ANY):_______________________

MEMBER ID# OR SS#: ________________________

PERSONAL INJURY INTAKE FORM

I. PERSONAL FACTS:

Name:____ DOB:_____________ SS#:

Address:

Drivers License Number: _________________________ Phone Number: __________________________

Employer: ____

Address of Employer:

____

____

Name of Supervisor: ______________________________Work Phone: ____________________________

Occupation: ____________________________ Beginning Date of Employment:____________________

Salary: $_______ per _______

Other Employment Compensation:

Bonuses: ____

Health Insurance: ____

Vacation Pay/Policy: ____

Pension/Profit Sharing: ____

Other: ____

Dates Lost From Work Because of This Injury: From__________ to ____________

Total Amount of Employment Compensation Lost: ____________________________________

II. ACCIDENT:

Date of Accident: ____

Time of Day: ____

Day of Week: ____

Location: ____

Weather Conditions: ____

Person who Caused the Accident (Indicate Name, Address, Telephone (if known), and Name of Employer: ____

____

____

____

____

Your Vehicle Information:

Make: ___________________ Model: _________________________ Year: __________

Color: ___________________________ License #: ______________________________

Registered Owner (Indicate Name, Address & Telephone): _______________________

Legal Owner (Indicate Name, Address & Telephone): ____________________________

Who Was Driving? (Indicate Name, Address, Telephone, Age, and Relationship to Legal Owner:

____

____

____

____

Damage to Vehicle (Also Indicate Whether Damage Repaired, Repair Cost/Estimate, Date of Repair): ____

____

____

Defendant Vehicle Information:

Make: ___________________ Model: _________________________ Year: __________

Color: ___________________________ License #: ______________________________

Registered Owner (Indicate Name, Address & Telephone): ________________________

Legal Owner (Indicate Name, Address & Telephone): ____________________________

Who Was Driving? (Indicate Name, Address, Telephone, Age, and Relationship to Legal Owner:

____

____

____

____

Damage to Vehicle (Also Indicate Whether Damage Repaired, Repair Cost/Estimate, Date of Repair): ____

____

____

Defendant Insurance (If Known):

Insurer (Indicate Name, Address & Telephone): _________________________________

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Policy #: ____

Have you Filed Any Reports With or Made Any Statements to Defendant's Insurer? If

Yes, Indicate Date(s) and Substance of Report/Statements): ________________________

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Were there any witnesses of the event: Y___ or N ___ If yes, please fill out the following:

A. Witness #1:

Name:____

Relationship:____

Phone Number:____

Address:____

____

B. Witness #2:

Name:____

Relationship:____

Phone Number:____

Address:____

____

General Description of What Happened:

____

____

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Accident Report:

Police Report: Yes ____ / No ____ Agency: ____________________________________

Other Reports? (Indicate Date and To Whom): __________________________________

____

Your Insurance:

Policy #: ____

Company Name, Address and Telephone: _______________________________________

____

Agent (Name and Telephone): ____

____

Insurance Claim/Report Made? (Indicate When and Substance of Claim/Report): ______

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____

Damages From This Accident:

Other Than Personal Injury (including car): _____________________________________

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____

Medical - Describe Your Injury and Condition Fully: ______________________________

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Hospital(s) Where Treated (Indicate Name, Address, Telephone, Dates of Admission and Release, and Amount of Charges; Attach Bills if Available: _______________________

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____

Doctors Seen for Diagnosis/Treatment (Indicate Name, Address, Telephone, Dates, and Amount of Charges; Attach Bills if Available: ________________________________

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____

Medical Procedures (Indicate All Medical Procedures, i.e. MRI, x-rays, ultrasounds, etc.):

____

____

Medication Prescribed (Indicate All Medication Taken in the Past and Present as a Result of the Accident and What Treatment the Medication is for): ______________________

____

____

Other Special Damages (e.g., Ambulance, Private Nurses, Extra Household Help, Transportation, Car Rental, Day Care) (Indicate To Whom Paid, Address, Dates, Amount of Charges; Attach Bills if Available): ______________________________________

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____

Prior Accidents Causing Injury to You (Include Dates): _______________________________

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Have you ever been a part of any legal proceedings prior (List all prior criminal and civil cases. Please briefly describe each event and provide the court in which the suit was filed, the case number and the final outcome): ____

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