

GOODRICH, QUAN & CHEUNG, LLP

ATTORNEYS AT LAW
8555 AERO DRIVE, SUITE 210
SAN DIEGO, CALIFORNIA, 92123
TELEPHONE: (858) 560-4529
FACSIMILE: (858) 560-8425

ATTORNEYS:

JOHN Q. GOODRICH, III
WM. DEREK QUAN
ALAN W. CHEUNG

OTHER OFFICE:

IMPERIAL COUNTY
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): _____

Defendant Insurance (If Known):

Insurer (Indicate Name, Address & Telephone): _____

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): _____

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:

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): _____

Damages From This Accident:

Other Than Personal Injury: _____

Medical - Describe Your Injury and Condition Fully: _____

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

Doctors Seen for Diagnosis/Treatment (Indicate Name, Address, Telephone, Dates, and

Amount of Charges; Attach Bills if Available: _____

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): _____

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

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): _____
