

PERSONAL INJURY DATA SHEET (AUTOMOBILE ACCIDENT)

Date: _____ Referred by: _____

Name: _____ SS# : _____

Date of Birth: _____

Spouse: _____ SS# : _____

Street/P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ (home) _____ (work)

_____ (cell) _____ (pager)

E-mail: _____

Name/Address of Employer: _____

Supervisor: _____ Position: _____ Rate of Pay: _____

Were you on the job or in the scope of your employment at the time of the incident? _____ Yes _____ No

Name/Address/Phone of Close Relative not living with you: _____

Name of Your Auto Insurance Company: _____

Type Coverage (check all that apply):

_____ Uninsured Motorist _____ Medical Payments _____ PIP

Private/Group Health Insurance Carrier: _____

Have you filed any medical bills pertaining to this incident on your health insurance? _____ Yes _____ No

Have you discussed this claim with any other lawyer? _____ Yes _____ No

Date of Accident: _____

Location of Accident (street or intersection): _____

City: _____ State: _____

What agency investigated the accident? _____

Name of Investigating Officer: _____

Have you brought a copy of the accident report? _____ Yes _____ No

If not, please briefly describe the accident: _____

Owner/Driver of other vehicle: _____

Address: _____

Other vehicle's insurance company: _____

Address: _____

Phone: _____ Adjuster: _____

Claim No.: _____

Have you ever had a personal injury of any kind (either before or since this accident)? _____ Yes _____ No

Please list the name and address of every person, including yourself, who was in your vehicle at the time of the accident:

Names

Addresses

_____	_____
_____	_____
_____	_____
_____	_____

Give the name and birthdate of any passenger in your vehicle who was a minor at the time and was injured:

Please list the treatment facilities (including ambulance) and physicians who were seen by each injured person:

_____	_____
_____	_____
_____	_____
_____	_____

Please list the pharmacies where you have had prescriptions filled for medications prescribed for your injuries:

If you were treated at Keesler Medical Center or at any other military medical facility, please give us the following information:

If you are active/retired military, indicate your branch of service:

If you are a military dependent, indicate the name and Social Security number of your sponsor, and his/her branch of the service:

Have you submitted any medical bills for payment by CHAMPUS/CHAMPVA? _____ Yes _____ No

Have you submitted any medical bills for payment by BLUE CROSS/BLUE SHIELD? _____ Yes _____ No

Have you submitted any medical bills for payment by MEDICAID or MEDICARE? _____ Yes _____ No

If yes, what state?

Are you receiving Social Security benefits? Yes No

If yes, what type?

Please describe your injuries and pain on the attached drawing.

PAIN DRAWING

Date _____

Name _____

Draw location of your pain on body outlines and mark how bad it is on pain line at bottom of page.

Ache
~~~~~  
^

Burning  
-----  
-----

Numbness  
oooo  
oo

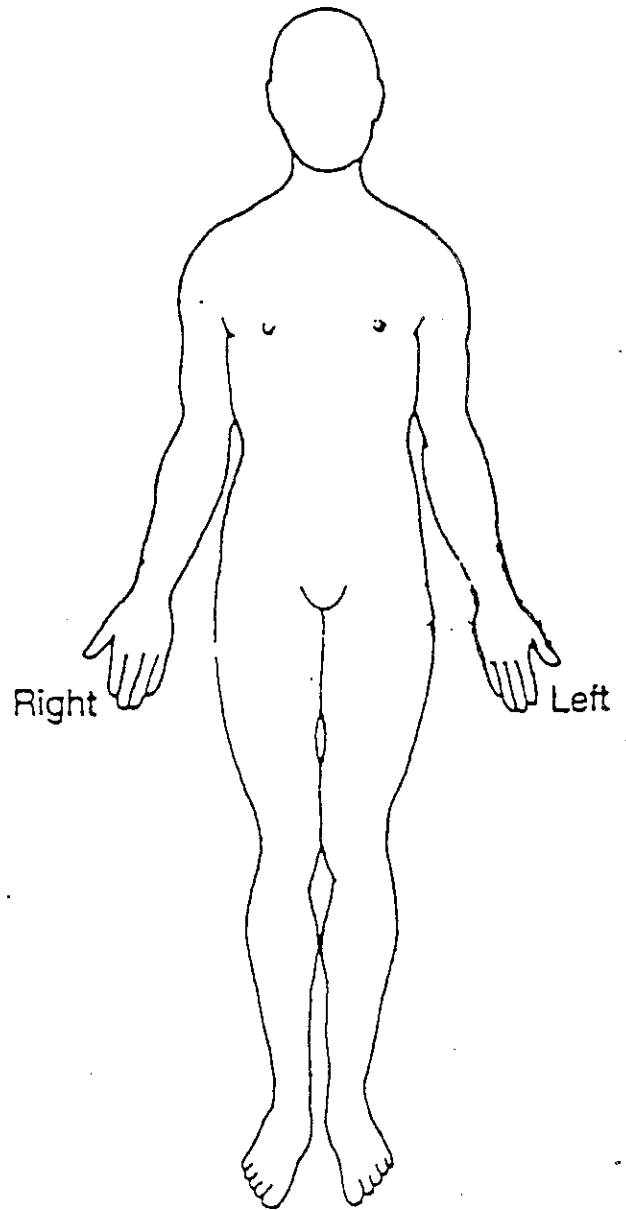
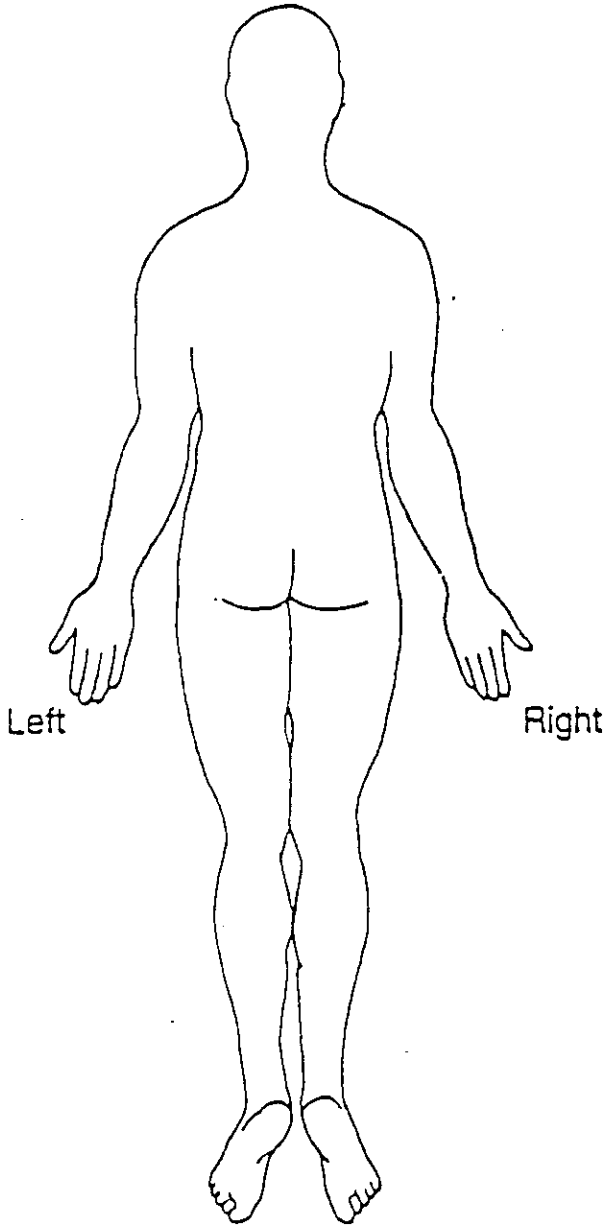
Pins and needles  
.....  
.....

Stabbing  
/////

Other  
xxxxx  
xxx

Back

Front



No pain

Worst possible pain

Pain line →

The patient with a complaint of back pain fills out a pain drawing using this