KANNIN LAW FIRM P.S.

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PERSONAL INJURY INTAKE

Intake Date_____ Referred by_____ Appt Date_____ File Open Date_____

Name of Injured Party:_____

Phone Numbers: Cell _____ Home:_____ Wk:_____ ER:_____

Mailing Address:_____

D/I:_____ S/L:_____ Name of Defendants:_____

Claim Type: MVA_____ Premises Liability_____ Maritme_____ Other Negligence_____

Accident/Injury Summary: (driver/passenger)_____

_____

_____

_____

Accident Date:_____ Time:_____ Location/Place:_____

City:_____ County:_____ State:_____

Accident Report:_____ Agency:_____ Officer:_____ Report:_____ Cite:_____

Injuries:_____

_____

_____ Seat Belt?_____

Treatment: Ambulance_____ ER/Hospital_____

F/U Treatment: Doctor / Clinic Name, Address & Phone:_____

_____

Additional Physicians:_____

_____

X Rays:_____ MRI:_____ CT Scan:_____ PT:_____

Name/Address of Family Dr. 2 years prior to injury:_____

_____

Significant Prior Health Problems or Diseases:_____

Prior Accidents/Injuries/Claims:_____

VEHICLE DAMAGE

Client's car: Minor/Moderate/Totaled? Parts damaged_____ Repair costs_____

Registered Owner_____ Make/Model/Yr:_____

Photos taken:_____ PD/WSP_____ Settled:_____ Amount:_____

Other driver's car: Minor/Moderate/Totaled Parts Damaged_____ Repair_____

Registered Owner:_____ Make/Model/Yr:_____

INSURANCE

Client's Auto Carrier:_____ PIP/UIM Coverage:_____

Claim/Policy Number:_____

Adjuster's Name:_____ Phone:_____

Address:_____ Email:_____

Policyholder's Name: (have client bring policy & declaration)_____

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PERSONAL INJURY INTAKE, PAGE 2

Name of Injured Party:_____

OTHER DRIVER'S INSURANCE

Name of Other Driver_____

Insurance Carrier_____ PIP/UIM Coverage:_____

Number:_____

Adjuster's Name:_____ Phone:_____

Address:_____ Email:_____

Policyholder's Name:_____

WITNESSES

1. Name/Address/Phone:_____

2. Name/Address/Phone:_____

PASSENGERS IN CLIENT'S VEHICLE?

1. Name/Address/Phone:_____

2. Name/Address/Phone:_____

Injured:_____ If yes, describe_____

WAGE LOSS

Employer:_____ Job Duties:_____

Address:_____ Phone:_____

Wages:_____ Average Wkly Hrs:_____ Time off since injury:_____

Supervisor's Name:_____ Length of employment:_____

PERSONAL

Health Insurance? Y/N Name of Plan:_____

DOB:_____ SSN:_____ Driver's License Number:_____

Spouse's Name:_____ Children:_____

Client's Hobbies, Recreational Activities, Sports:_____

_____

NOTES:_____

_____

_____

_____

TO DO:

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____