

ACCIDENT INTAKE FORM - AUTO CASES

PLAINTIFFS NAME:

1ST _____

D of B _____

SS # _____

2ND _____

D of B _____

SS # _____

3RD _____

D of B _____

SS # _____

PLAINTIFFS ADDRESS:

PHONE:

1ST _____

HOME: _____

WORK: _____

CELL: _____

2ND _____

HOME: _____

WORK: _____

CELL: _____

3RD _____

HOME: _____

WORK: _____

CELL: _____

DEFENDANTS:

1ST _____ ADDRESS _____

2ND _____ ADDRESS _____

3RD _____ ADDRESS _____

DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

PLACE OF ACCIDENT: _____

DESCRIPTION OF ACCIDENT: _____

INJURIES SUSTAINED: _____

PLAINTIFF'S AUTO: MAKE _____
MODEL _____
LICENSE NUMBER: _____

DEFENDANT'S AUTO(S)
DESCRIBE MAKE AND MODEL:

1ST:	_____	LICENSE:	_____
2ND:	_____	LICENSE:	_____
3RD:	_____	LICENSE:	_____
4TH:	_____	LICENSE:	_____

POLICE AGENCY: _____
ADDRESS _____
OFFICER: _____ BADGE NO: _____
POLICE REPORT NO: _____

HOSPITALS

1. NAME: _____
ADDRESS: _____
ADMITTED: _____
DISCHARGED: _____

DOCTORS:

1ST _____ TYPE _____
ADDRESS _____
PHONE: _____

2ND _____ TYPE _____
ADDRESS _____
PHONE: _____

3RD _____ TYPE _____
ADDRESS _____
PHONE: _____

4TH _____ TYPE _____
ADDRESS _____
PHONE: _____

PLAINTIFF'S EMPLOYERS (NAME ALL FOR LAST THREE YEARS):

1ST _____
ADDRESS _____
PHONE: _____
POSITION: _____ SALARY: _____

2ND _____
ADDRESS _____
PHONE: _____
POSITION: _____ SALARY: _____

3RD _____
ADDRESS _____
PHONE: _____
POSITION: _____ SALARY: _____

4TH _____
ADDRESS _____
PHONE: _____
POSITION: _____ SALARY: _____

INSURANCE INFORMATION:

PLAINTIFF'S MEDICAL INSURANCE / NO-FAULT INSURANCE:

COMPANY _____
ADDRESS: _____
FILE NO: _____ POLICY #: _____
POLICY HOLDER: _____
ADJUSTER: _____ PHONE: _____
FAX: _____

1ST DEFENDANT'S INSURANCE:

COMPANY _____
ADDRESS: _____
FILE NO: _____ POLICY #: _____
POLICY HOLDER: _____
ADJUSTER: _____ PHONE: _____
FAX: _____

2ND DEFENDANT'S INSURANCE:

COMPANY _____
ADDRESS: _____
FILE NO: _____ POLICY #: _____
POLICY HOLDER: _____
ADJUSTER: _____ PHONE: _____
FAX: _____

3rd DEFENDANT'S INSURANCE:

COMPANY _____
ADDRESS: _____
FILE NO: _____ POLICY #: _____
POLICY HOLDER: _____
ADJUSTER: _____ PHONE: _____
FAX: _____

WITNESSES:

NAME _____ ADDRESS _____
PHONE# _____

NAME _____ ADDRESS _____
PHONE# _____

NAME _____ ADDRESS _____
PHONE# _____

PICTURES OF VEHICLES AVAILABLE: YES: _____ NO: _____

LIST ANY OTHER PERTINENT FACTS:
