

**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:

1<sup>ST</sup> \_\_\_\_\_  
\_\_\_\_\_

HOME: \_\_\_\_\_

WORK: \_\_\_\_\_

CELL: \_\_\_\_\_

2<sup>ND</sup> \_\_\_\_\_  
\_\_\_\_\_

HOME: \_\_\_\_\_

WORK: \_\_\_\_\_

CELL: \_\_\_\_\_

3<sup>RD</sup> \_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

1<sup>ST</sup> DEFENDANT'S INSURANCE:

COMPANY \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
FILE NO: \_\_\_\_\_ POLICY #: \_\_\_\_\_  
POLICY HOLDER: \_\_\_\_\_  
ADJUSTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

2<sup>ND</sup> DEFENDANT'S INSURANCE:

COMPANY \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
FILE NO: \_\_\_\_\_ POLICY #: \_\_\_\_\_  
POLICY HOLDER: \_\_\_\_\_  
ADJUSTER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

3<sup>rd</sup> 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:

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