WELCOME!

THE TOUGH HONEST JOHN FAGAN ACCIDENT LAWYER

A PROFESSIONAL ASSOCIATION

AUTO INJURY INTAKE

DATE OF ACCIDENT: _____/_____/_____

PLEASE TELL US ABOUT YOURSELF

First Name:_____ Middle_____ Last_____

Address:_____

City:_____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Mobile Phone: (____) _____ - _____ Name of Mobile provider?_____

Social Security #_____ Date of Birth:_____/_____/_____

Marital Status: ☒ Single ☒ Married, Date:____/____/_____ Spouse's Name: _____

☒ Separated, Date:____/____/_____ ☒ Divorced, Date:____/____/_____ ☒ Widowed, Date: ____/____/_____

Children: ☒ Yes ☒ No If yes, how many? _____ Highest school grade completed: _____

Do you have a current driver's license, or identification card? ☒ Yes / ☒ No If so: State of _____

Driver's License # _____

Email Address:_____

PLEASE TELL US HOW YOU HEARD ABOUT OUR OFFICE

How did you hear about our office? (Please check all that apply)

☒ TV ☒ Internet ☒ Road Sign ☒ Relative ☒ Friend ☒ Former Client ☒ Phone Book ☒ Referral Service

☒ Other, please explain:_____

_____

(Turn Over for page 2)

PLEASE TELL US ABOUT YOUR ACCIDENT

Date of Accident: _____/_____/_____ Time of Accident: ____:_____ ❒ AM ❒ PM

Date Employer Notified: _____/_____/_____ Person Notified: _____

Accident Location: _____

City:_____ County: _____ State: _____

Accident Description:_____

_____

_____

_____

_____

Which law enforcement agency responded to the accident? _____

Do you know of any witnesses to accident, or persons with knowledge of accident? ❒ Yes ❒ No

If so, please list below:

Name:_____Phone Number: (_____)_____-_____

Name:_____ Phone Number: (_____)_____-_____

Name:_____ Phone Number: (_____)_____-_____

PLEASE TELL US ABOUT YOUR ACCIDENT INJURIES

Injuries You Received: _____

_____

_____

_____

_____

Did you go to the ER / hospital? _____ If yes, which hospital?_____

Were you taken by ambulance? _____ If no, how did you get there?_____

PLEASE TELL US ABOUT THE HOSPITALS/CLINICS WHERE YOU WERE TREATED

Hospital/Clinic: _____ Date(s): _____/_____/_____to_____/_____/_____

Hospital/Clinic: _____ Date(s): _____/_____/_____to_____/_____/_____

Hospital/Clinic: _____ Date(s): _____/_____/_____to_____/_____/_____

Hospital/Clinic: _____ Date(s): _____/_____/_____to_____/_____/_____

Hospital/Clinic: _____ Date(s): _____/_____/_____to_____/_____/_____

LIST THE DOCTORS WHO YOU HAVE SEEN **IN THE ORDER YOU SAW THEM**

Physician #1: _____ Dates Seen: ____/____/____ to ____/____/__

Injury: _____

Physician #2: _____ Dates Seen: ____/____/____ to ____/____/__

Injury: _____

Physician #3: _____ Dates Seen: ____/____/____ to ____/____/__

Injury: _____

Physician #4: _____ Dates Seen: ____/____/____ to ____/____/__

Injury: _____

Physician #5: _____ Dates Seen: ____/____/____ to ____/____/__

Injury: _____

HAS ANY DOCTOR GIVEN YOU A DISABILITY RATING?

Rating Physician: _____ MMI Date: ____/____/____ Rating: _____%

Rated Injury: _____

Rating Physician: _____ MMI Date: ____/____/____ Rating: _____%

Rated Injury: _____

WHO IS YOUR FAMILY PHYSICIAN?

Name: _____ Phone Number: (____) _____ - _____

Address: _____

City: _____ State: _____ Zip : _____

How long has he/she been your family physician? _____

PLEASE TELL US ABOUT YOUR VEHICLE

Year: _____ Make: _____ Model: _____ Color: _____

Odometer Reading: At time of accident: _____ Currently: _____

Options: _____

Lienholder Name: _____ Lienholder Phone: (____) _____ - _____

Loan Number: _____

(Turn Over for page 4)

PLEASE TELL US ABOUT **YOUR** AUTOMOBILE INSURANCE CARRIER

Insurance Company:_____ Policy Number:_____

Adjuster:_____ Claim Number: _____

Phone Numbers:_____

Address:_____

City: _____ State: _____ Zip: _____

PLEASE TELL US ABOUT THE **OTHER** DRIVER'S AUTOMOBILE INSURANCE CARRIER

Insurance Company:_____ Policy Number:_____

Adjuster:_____ Claim Number: _____

Phone Numbers:_____

Address:_____

City: _____ State: _____ Zip: _____

INJURIES/ACCIDENTS YOU HAVE HAD BEFORE YOUR ACCIDENT

Have you had ANY injuries prior to this accident that required medical attention? Please tell us:

Date _____/_____/_____ Types of injuries: _____ Legal action taken?___

Date _____/_____/_____ Types of injuries: _____ Legal action taken?_____

Date _____/_____/_____ Types of injuries: _____ Legal action taken?___

PLEASE TELL US ABOUT YOUR EMPLOYMENT AT THE TIME OF YOUR INJURY

EMPLOYER #1

Occupation: _____ Work Responsibilities:_____

Employer's Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Supervisor:_____ Benefits Coordinator:_____

Phone: (____)_____-_____ Length of Employment:_____Years_____Months

Hours per Week:_____ Pay Rate:_____ Gross Pay Per Week:_____

Fringe Benefits:_____

EMPLOYER #2

Occupation: _____ Work Responsibilities:_____

Employer's Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Supervisor:_____ Benefits Coordinator:_____

Phone: (____)_____-_____ Length of Employment:_____Years_____Months

Hours per Week:_____ Pay Rate:_____ Gross Pay Per Week:_____

Fringe Benefits:_____

PLEASE TELL US ABOUT YOUR **CURRENT** EMPLOYMENT **IF DIFFERENT** FROM ABOVE

Employer's Name:_____ Address:_____

City:_____ State:_____ Zip:_____

Supervisor:_____ Benefits Coordinator:_____

Phone: (____)_____-_____ Length of Employment:_____Years_____Months

Hours per Week:_____ Pay Rate:_____ Gross Pay Per Week:_____

PLEASE TELL US ABOUT THE STATUS OF YOUR CASE

Have you missed time from work? ❒ Yes ❒ No Was the accident work-related? ❒ Yes ❒ No

How much time have you missed from work: _____ Are you still off work? ❒ Yes ❒ No

Are you receiving any wage-loss benefits? ❒ Yes ❒ No If so, what is the amount of your bi-weekly check: $_____

Do you have medical expenses unpaid? ❒ Yes ❒ No Do you have lost wages unpaid? ❒ Yes ❒ No

PLEASE TELL US ABOUT YOUR HEALTH INSURANCE / DISABILITY INSURANCE

Do you have health insurance? ❒ Yes ❒ No If yes, which health insurance company: _____

Policy #: _____ Member I.D. #: _____Other #: _____

Do you receive ❒ SOCIAL SECURITY DISABILITY ❒ MEDICARE ❒ SSI ❒ MEDICAID?

Has your HEALTH INSURANCE or MEDICARE / MEDICAID paid any of your bills? ❒ Yes ❒ No

Do you have Short or Long Term Disability insurance? ❒ Yes ❒ No

If yes, name of Disability Insurance Company: _____

PLEASE TELL US ABOUT ANY DIFFICULTIES YOU ARE HAVING

_____

_____

_____

IF YOU HAVE BEEN PREVIOUSLY REPRESENTED BY AN ATTORNEY FOR **THIS** ACCIDENT, PLEASE TELL US

Attorney Name:_____Phone: (____)_____-_____

Address:_____City:_____ State: _____ Zip: _____

FOR OFFICE USE ONLY:

Intake Date: _____/_____/_____ Statute of Limitations:_____/_____/_____

Notes: _____

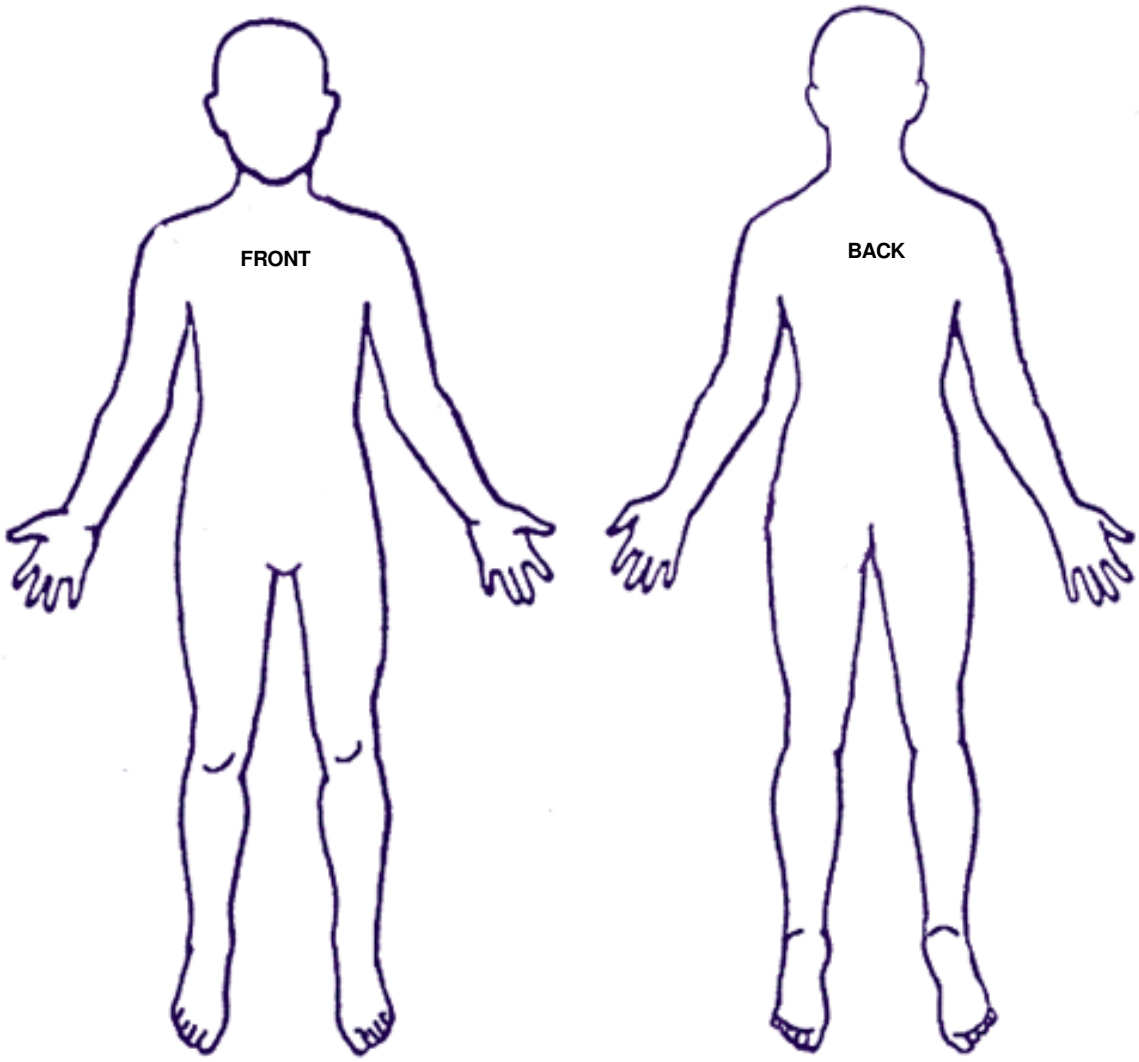
_____

_____

_____

(Turn Over for page 6

ON THE DIAGRAM, PLEASE CIRCLE OR PLACE AN X
ON THE PART(S) OF YOUR BODY THAT WAS INJURED



PLEASE DRAW ON THE DIAGRAM HOW YOUR ACCIDENT OCCURRED.

Use the diagram to reconstruct the locations of the cars and witnesses. Show the direction of travel of all the vehicles, the location of traffic signals and signs and any other markings or characteristics of the scene.