For Office Use Only

File No.______________________ Liability: G F P

Date Opened__________________________ Injury: T S

Companion Case____________________ Driver Passenger Ped

Medpay____ Health ____ Lien______ Interviewer:_______________

Last name____________________________ First name_________________ MI_________

Street address____

City__________________________ State____________ Zip Code____________________

Telephone (Home)____________________ (Work)__________________________

Social Security #___________________________ Date of birth____________

Sex: M F Driver's license #____________ State_______

Spouse____________________________If minor, parent(s) name______________________

Emergency contact________________________________

Address_____________________________________City_____________ State_______ Zip Code________Telephone (Home)_____________ (Work)______________

How did you hear about Ginsberg Law Offices, P.C.?___________________________________
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Date of accident______________ Time_______________

Location____

____

City__________ County__________ State__________

Responding police department__________________________

Report #____________ # of vehicles in accident_________

Please briefly describe the accident ____

____

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YOUR INJURIES

Please list all of the injuries you sustained in this accident ______________________________

____

What is your most serious injury? ____________________________________

Were you transported to the hospital by ambulance? YES NO

If yes, which ambulance company transported you? ________________

Please list all of the hospitals where you have received treatment and/or testing for your injuries:

Hospital Date of treatment

____

____

Please list all of the doctors and/or other medical providers that have treated you for your injuries:

Provider Address/telephone number

____

____

____

PRIOR INJURIES

Prior to this accident, have you ever been injured in an automobile or work-related accident?
YES NO
If yes, please list the type and approximate date of the injury:

Date Injury

____

____

Prior to this accident, have you ever had an injury similar to the one(s) you now have?

YES NO

If yes, please explain:

____

Prior to this accident, have you ever made a claim for personal injury, disability insurance and/or workers' compensation? YES NO

If yes, please explain:____

____

Who was your attorney?______________________________
****

YOUR VEHICLE

Please list the name, address and telephone number of the owner of the vehicle you were in at the time of the accident:

____

Make___________ Model___________ Year___________Tag #___________ State__________

Type of damage___________________________________Location of vehicle________________

_______________How many people were in your vehicle at the time of the accident?_______

For each person who was in your vehicle at the time of the accident, please list his or her full name, address, telephone number and their position in the vehicle:

____

____

_***

YOUR INSURANCE COVERAGE

Your automobile insurance company_________________________

Policy number_______________ Insured________________

Types of coverage: MEDPAY UNINSURED/UNDERINSURED MOTORIST LOST WAGES

Have you reported this accident to your automobile insurance company?

YES NO

Your health insurance company___________________________

Policy number_______________ Insured_______________

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THE OTHER VEHICLE

Name of the adverse driver_____________________________

Address_______________________________________City___________ State___________ Zip code_________Telephone (Home)______________ (Work)_______________

Driver's license #_______________ # of passengers_________

Make___________ Model___________ Year__________

Is the driver of the vehicle also the owner? YES NO

If no, please list the name, address and telephone number of the owner of the vehicle that caused the accident:

____

Insurance company_________________________________Policy #_______________

Claim #_________________

Have you been contacted by the adverse party's insurance company? YES NO

If yes, who contacted you?____________________________

Have you given a recorded statement to this insurance company? YES NO

If yes, when?__________________________________
****

WITNESSES

Name____

Address______________________________________City__________ State__________ Zip code________Telephone (Home)_____________ (Work)_______________

Is this witness favorable to you? YES NO

Name____

Address______________________________________City__________ State__________ Zip code________Telephone (Home)_____________ (Work)_______________

Is this witness favorable to you? YES NO

Name____

Address______________________________________City__________ State__________ Zip code________Telephone (Home)_____________ (Work)_______________

Is this witness favorable to you? YES NO
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YOUR EMPLOYER

Employer_____________________________________

Address______________________________________City__________ State__________ Zip

code________Telephone_____________ Supervisor_________________

Your position__________ Duties____

__________Number of hours worked per day____ Number of days worked per week____

Rate of pay $_______ per HOUR DAY WEEK MONTH YEAR

Have you lost time from work as a result of your injuries? YES NO

If yes, how much time have you lost?______________________

Is the disability continuing? YES NO
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Is there anything you would like to add?____

____

____

____

I verify that the above information is accurate to the best of my knowledge.

____
Client's Signature