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MVA CONFIDENTIAL CLIENT INFORMATION FORM

This questionnaire is a confidential questionnaire for the use of our office only in preparing your claim for personal injuries. The information you furnish us will not be released and will be held strictly confidential. When your claim has been concluded, we will return this questionnaire to you if you wish. Please answer every question fully and accurately, because as your attorneys, we must know all about you and your case. One surprise, because of an incorrect or incomplete answer could cause you to lose your case.

CASE INFORMATION

YOUR NAME: ____

DATE OF ACCIDENT: ______________________________________

YOUR INSURANCE COMPANY: ________________________________

CLAIM NUMBER (IF KNOWN): ________________________________

TORT THRESHOLD: ____

PLAINTIFF INFORMATION

1. FULL NAME: ____
   First Middle Last

2. BIRTHPLACE: ____

3. DATE OF BIRTH: _______________________________________

4. SOCIAL SECURITY NUMBER: _______________________________

5. ADDRESS: ____

6. PHONE NUMBER: HOME: ________________ WORK: _______________

   CELL: ____________________

7. E-MAIL ADDRESS: ____

8. MARITAL STATUS: ____

9. SPOUSE'S NAME: ____

10. IF DIVORCED, DATE AND PLACE: _________________________________

11. IF SPOUSE DECEASED, DATE OF DEATH: __________________________

12. NAMES, AGES AND ADDRESS OF ALL THOSE (INCLUDING CHILDREN) WHO ARE DEPENDENT UPON YOU FOR SUPPORT, AND YOUR RELATIONSHIP TO EACH:

NAME	ADDRESS	AGE	RELATIONSHIP

13. NAME, ADDRESS, E-MAIL AND PHONE NUMBER OF FAMILY MEMBER OR FRIEND WHO WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU FOR ANY REASON:

____

____

____

14. PLEASE PROVIDE ALL ADDRESSES FOR THE LAST TEN YEARS, THE DATES OF THE RESIDENCE, THE PERSONS RESIDING AT THE ADDRESSES WITH PLAINTIFF AND THE RELATION, IF ANY, TO THE PLAINTIFF.

____

____

____

CLIENT'S INSURANCE

1. NAME OF AUTOMOBILE INSURANCE COMPANY, POLICY NUMBER, NAMED INSURED AND EFFECTIVE DATES OF POLICY:

____

____

PLEASE PROVIDE A COPY OF YOUR INSURANCE POLICY OR DECLARATION PAGE.

2. WHAT ARE THE UIM POLICY LIMITS ON YOUR INSURANCE POLICY?

____

3. DO YOU HAVE THE LAWSUIT (VERBAL) THRESHOLD OR NO THRESHOLD?
_____ THRESHOLD _____ NO THRESHOLD

4. DO YOU HAVE HEALTH OR ACCIDENT INSURANCE? IF SO, GIVE THE NAME OF THE COMPANY (S) AND POLICY NUMBER (S):

____

5. DOES ANY OTHER MEMBER/RESIDENT OF YOUR HOUSEHOLD OWN AN AUTOMOBILE INSURED UNDER A DIFFERENT POLICY OF INSURANCE? IF SO, PLEASE LIST INSURANCE COMPANY, POLICY NUMBER, AND UM/UIM LIMITS.

____

ADDITIONAL INSURANCE

1. ARE YOU ELIGIBLE FOR MEDICARE? _____ YES _____ NO

2. ARE YOU ELIGIBLE FOR MEDICAID? _____ YES _____ NO

IF SO, PLEASE LIST MEDICARE AND/OR MEDICAID ID NUMBER.

____

3. PLEASE STATE THE NAME AND POLICY NUMBER OF YOUR HEALTH INSURANCE COMPANY: ______________________________

4. PLEASE CHECK IF ANY OF YOUR MEDICAL BILLS HAVE BEEN SUBMITTED TO ANY OF THE FOLLOWING:

______ MEDICARE/MEDICAID
______ HEALTH INSURANCE COMPANY
______ ______________________ (Other - Please complete name of company)

IF YOUR MEDICAL BILLS HAVE BEEN SUBMITTED TO MEDICARE, MEDICAID AND/OR YOUR PRIVATE HEALTH INSURANCE COMPANY, THERE MAY BE A LIEN ON THE MONEY PAID BY YOUR INSURER.

PLEASE PROVIDE A COPY OF YOUR MEDICARE, MEDICAID AND/OR HEALTH INSURANCE CARD.

OTHER INFORMATION

1. DO YOU BELONG TO ANY SOCIAL NETWORKING SITES (e.g., Facebook, Twitter, MySpace, LinkedIn, Bebo, hi5, Orkut, PerfSpot, Yahoo!360, Zorpia, Netlog, Snapchat, Instagram, etc.)? _____ YES _____ NO

2. IF SO, LIST EACH SITE TO WHICH YOU BELONG AND YOUR USERNAME OR HANDLE FOR EACH ACCOUNT:

SITE: ________________________ USERNAME/HANDLE: ______________________

SITE: ________________________ USERNAME/HANDLE: ______________________

SITE: ________________________ USERNAME/HANDLE: ______________________

(IF YOU NEED MORE SPACE, YOU MAY ATTACH EXTRA PAGES)

WARNING! ANY INFORMATION, PICTURES, OR VIDEOS POSTED ON SOCIAL NETWORKING SITES MAY AFFECT YOUR CLAIM. EVEN IF YOU HAVE LIMITED WHO MAY ACCESS YOUR ACCOUNT, ALL INFORMATION MAY BE SHARED IN LITIGATION THROUGH THE DISCOVERY PROCESS.

IN NO EVENT SHOULD YOU DELETE ANY INFORMATION FROM YOUR SOCIAL MEDIA SITES, NOR SHOULD YOU TAKE DOWN YOUR PROFILES, AS THAT MAY BE HELD TO BE A VIOLATION OF YOUR DUTY TO PRESERVE ALL EVIDENCE RELEVANT TO YOUR CLAIM.

3. IF YOU OR ANY OTHER PARTY OR WITNESSES KNOWN TO YOU CONSUMED ANY ALCOHOLIC BEVERAGES, DRUGS OR MEDICATION, INCLUDING PRESCRIPTION MEDICATION WITHIN TWELVE (12) HOURS BEFORE THE ACCIDENT, STATE THE NAME OF THE PERSON; WHAT WAS CONSUMED; THE QUANITTY; WHERE CONSUMED AND THE NAMES AND ADDRESSES OF ALL PERSONS PRESENT.

____

____

____

FACTS OF THE ACCIDENT

1. DATE: ________________ DAY: ___________________ TIME: ________________

2. DAYLIGHT, DUSK OR DARK? ____

3. WEATHER: ____

4. GIVE THE EXACT LOCATION AND DESCRIBE WHAT HAPPENED:

____

____

____

____

FACTS CONCERNING THE OTHER PARTY

1. NAME OF OTHER PARTY: ____

2. ADDRESS: ____

3. OTHER PARTY'S INSURANCE COMPANY: ______________________________

4. GIVE YOUR OBSERVATIONS ABOUT THE PARTY AS A PERSON:

____

AUTOMOBILE INFO

1. MAKE, MODEL AND YEAR OF YOUR CAR:______________________________

____

2. OPERATOR OF YOUR CAR: ____

3. DAMAGE TO YOUR CAR: ____

4. WERE YOU REIMBURSED BY YOUR INSURANCE COMPANY FOR THE DAMAGE TO YOU CAR? _____ YES _____ NO

5. DID YOU HAVE TO RENT A CAR? _____ YES _____ NO
IF SO, GIVE THE NAME OF THE COMPANY & THE AMOUNT OF THE RENTAL:

____

6. DAMAGE TO THE OTHER CAR: ____

____

7. WERE THERE OTHER PEOPLE IN YOUR CAR? _____ YES _____ NO
IF SO, LIST THEIR NAMES, ADDRESSES AND WHERE SEATED IN THE CAR:

____

____

8. WAS THERE A POLICE REPORT? _____ YES _____ NO
IF SO, NAME OF POLICE DEPT.:____

WITNESSES

LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL WITNESSES TO THE ACCIDENT. (PERSON WHO SAW OR MAY HAVE SEEN THE ACCIDENT).

1. NAME: ____

   ADDRESS: ____

   PHONE: ________________________ AGE: ___________ JOB: ____________

   WHAT DOES HE/SHE KNOW: ____

2. NAME: ____

   ADDRESS: ____

   PHONE: ________________________ AGE: ___________ JOB: ____________

   WHAT DOES HE/SHE KNOW: ____

PLEASE ALSO LIST ANY PEOPLE WHO MAY HAVE INFORMATION ABOUT THE ACCIDENT OR THE CONDITION THAT CAUSED THE ACCIDENT.

1. NAME: ____

   ADDRESS: ____

   PHONE: ________________________ AGE: ___________ JOB: ____________

   WHAT DOES HE/SHE KNOW: ____

2. NAME: ____

   ADDRESS: ____

   PHONE: ________________________ AGE: ___________ JOB: ____________

   WHAT DOES HE/SHE KNOW: ____

LIST OF NAMES

List ten names and addresses of people who can best explain how the injuries from the accident have affected your life including changes in your activities since the accident. These people may include family, friends, neighbors, co-workers, etc. This list of names should also include people who performed hobbies and activities with you that you can no longer perform due to the injuries sustained in the accident.

1. NAME: ____

   ADDRESS: ____

2. NAME: ____

   ADDRESS: ____

3. NAME: ____

   ADDRESS: ____

4. NAME: ____

   ADDRESS: ____

5. NAME: ____

   ADDRESS: ____

6. NAME: ____

   ADDRESS: ____

7. NAME: ____

   ADDRESS: ____

8. NAME: ____

   ADDRESS: ____

9. NAME: ____

   ADDRESS: ____

10. NAME: ____

    ADDRESS: ____

PHOTOGRAPHS

DO YOU HAVE PHOTOGRAPHS OF THE SITE OF YOUR ACCIDENT OR YOUR DAMAGES? _____ YES _____ NO

IF YES, PLEASE SEND THE PHOTOGRAPHS TO OUR OFFICE.

IF NO, PLEASE MAKE SURE YOU OBTAIN PHOTOGRAPHS IMMEDIATELY.

STATEMENTS MADE

1. HAVE YOU TOLD ANY POLICE OFFICER, INVESTIGATOR, INSURANCE ADJUSTER OR ANY OTHER PERSON ABOUT THE ACCIDENT?
_____ YES _____ NO

2. HAVE YOU GIVEN ANY WRITTEN STATEMENT TO ANY PERSON ABOUT THE ACCIDENT? _____ YES _____ NO

IF SO, ANSWER THE FOLLOWING:

A. NAME OF THE PERSON TO WHOM THE STATEMENT WAS GIVEN:
____

B. DATE GIVEN: ____

C. PERSONS PRESENT AT THE TIME:
____

D. IF WRITTEN DO YOU HAVE A COPY? _____ YES _____ NO

E. DID YOU SIGN THE STATEMENT? _____ YES _____ NO

3. PLEASE GIVE US ANY STATEMENT YOU KNOW THE OTHER PARTY MADE ABOUT THE ACCIDENT, OR THAT YOU UNDERSTAND HE/SHE MAY HAVE MADE:
____
____
____

4. WHEN AND WHERE MADE: ____

5. NAME AND ADDRESS OF PERSON WHO HEARD IT:

____

____

DAMAGES FROM THE ACCIDENT

THE AMOUNT OF RECOVERY MADE IN THIS CASE WILL BE AFFECTED BY THE DAMAGES OR EXPENSES INCURRED AS A RESULT OF YOUR ACCIDENT. IT IS IMPORTANT THAT YOU FULLY LIST ALL INFORMATION REGARDING YOUR INJURIES AND YOUR EXPENSES AS A RESULT OF THIS ACCIDENT.

1. STATE IN FULL DETAIL, ALL INJURIES YOU RECEIVED AS A RESULT OF THE ACCIDENT:

____

____

____

____

____

2. STATE YOUR PRESENT PHYSICAL CONDITION - SCARS, DEFORMITIES, HEADACHES, PAINS, ETC., DUE TO INJURIES SUSTAINED IN THIS ACCIDENT:

____

____

____

____

____

3. HAVE YOU MISSED ANY TIME FROM WORK AS A RESULT OF YOUR INJURY? IF SO, LIST THE INCLUSIVE DATES YOU WERE UNABLE TO WORK:

FROM: ____________________________ TO: __________________________________

FROM: ____________________________ TO: __________________________________

4. DID YOU LOSE WAGES FOR THE PERIODS OF TIME MISSED FROM WORK DUE TO THIS ACCIDENT? _____ YES _____ NO

IF SO, STATE THE TOTAL WAGES LOST TO DATE AND THE DATES.

____

5. LIST ALL HOSPITALS IN WHICH YOU WERE EXAMINED OR TREATED, OR TO WHICH YOU WERE ADMITTED AS A PATIENT AS A RESULT OF THE INJURIES SUSTAINED IN THE ACCIDENT, THE DATES AND THE TOTAL COSTS:

A. HOSPITAL: ____

ADDRESS: ____

DATE OF EMERGENCY ROOM TREATMENT: _______________________

DATES OF ADDMISSION: FROM: _____________ To: _________________

B. HOSPITAL: ____

ADDRESS: ____

DATE OF EMERGENCY ROOM TREATMENT: _______________________

DATES OF ADDMISSION: FROM: _____________ To: _________________

6. LIST THE FULL NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PHYSICIAN OR SURGEON WHO HAS EXAMINED OR TREATED YOU FOR YOUR INJURIES AS A RESULT OF THE ACCIDENT:

A. DOCTOR'S NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

TYPE OF TREATMENT: ____

B. DOCTOR'S NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

TYPE OF TREATMENT: ____

7. IF YOU WERE GIVEN PHYSICAL THERAPY OR OTHER THERAPY NOT DIRECTLY GIVEN BY A PHYSICIAN, LIST THE FULL NAME, ADDRESS AND TELEPHONE NUMBER OF EACH MEDICAL PROVIDER AND STATE WHAT PHYSICIAN ORDERED EACH PARTICULAR THERAPY:

A. THERAPY PROVIDER: ____

ADDRESS: ____

PHONE NUMBER: ____

PHYSICIAN WHO ORDERED THERAPY: ____________________________

APPROXIMATE DATES OF THERAPY: ______________________________

B. THERAPY PROVIDER: ____

ADDRESS: ____

PHONE NUMBER: ____

PHYSICIAN WHO ORDERED THERAPY: ____________________________

APPROXIMATE DATES OF THERAPY: ______________________________

8. LIST HERE ALL OF YOUR USUAL ACTIVITIES WHICH YOU HAVE NOT BEEN ABLE TO PERFORM, OR CAN ONLY PERFORM WITH DIFFICULTY, SINCE THE ACCIDENT, SUCH AS CLIMBING STAIRS, IRONING, CUTTING GRASS, DANCING, LIFTING CHILDREN, ETC?

____

____

9. IF YOU ARE A STUDENT, LIST THE TIME LOST FROM SCHOOL:

____

10. PERIOD OF TIME YOU WERE CONFINED TO YOUR HOUSE: ______________

____

WORK BACKGROUND

1. PRESENT JOB TITLE: ____

2. NAME, ADDRESS AND TELEPHONE NUMBER OF EMPLOYER:

____

3. PRESENT JOB TITLES AND DUTIES: _________________________________

____

4. HOW LONG HAVE YOU WORKED AT THIS JOB? _______________________

5. PRESENT SALARY: ____

6. PLEASE ATTACH COPIES OF FIVE RECENT PAY CHECK STUBS.

7. PLEASE ATTACH COPIES OF YOUR LAST FIVE FEDERAL AND STATE INCOME TAX RETURNS INCLUDING W-2'S.

8. PLEASE LIST YOUR EDUCATION AND DEGREES INCLUDING THE INSTITUTIONS YOU ATTENDED AND THE DATES YOU RECEIVED YOUR DEGREES. ____

____

____

9. WERE YOU IN THE COURSE OF YOUR EMPLOYMENT AND/OR PERFORMING YOUR JOB DUTIES WHEN THE ACCIDENT HAPPENED? ____________________

IF YES, WAS YOUR EMPLOYER NOTIFIED OF THE ACCIDENT? __________

IF YES, WHO WAS NOTIFIED? ____________________________________

10. NAME, ADDRESS, TELEPHONE NUMBER, POLICY NUMBER AND CLAIM NUMBER OF YOUR EMPLOYER’S WORKERS COMPENSATION INSURANCE COMPANY IF KNOWN: ____

____

11. SHOULD A WORKERS COMPENSATION CLAIM BE FILED? _____________

12. IF NOT WORKING FOR THIS EMPLOYER AT THE TIME OF YOUR ACCIDENT, STATE THE FOLLOWING:

NAME OF EMPLOYER: ____

ADDRESS: ____

JOB TITLE & TYPE OF WORK: ____

RATE OF PAY: ____

HOURS PER WEEK REGULARLY WORKED: __________________________

13. WHAT DID YOU EARN IN THE YEAR BEFORE YOUR ACCIDENT TOOK PLACE: ____

MEDICAL HISTORY BEFORE ACCIDENT

1. NAME AND ADDRESS OF FAMILY PHYSICIAN: _________________________

____

2. HAVE YOU HAD ANY HEALTH PROBLEMS (IT IS IMPORTANT THAT WE KNOW THIS INFORMATION BECAUSE THE RECORDS OF ANY PHYSICIAN YOU HAVE SEEN IN THE PAST YEARS WILL PROBABLY BE SUBPOENAED BY THE DEFENSE) AS TO EACH HEALTH PROBLEM, PLEASE STATE THE FOLLOWING:

A. DESCRIBE THE HEALTH PROBLEM: ________________________________

B. DATES EACH CONDITION WAS ACTIVE: ____________________________

C. NAME & ADDRESS OF EACH TREATING PHYSICIAN:

____

____

D. KIND OF TREAMENT RENDERED: __________________________________

E. IF HOSPITALIZED AS A RESULT LIST WHERE & WHEN:

____

F. ARE YOU STILL UNDER TREATMENT OR MEDICAITON, IF SO, DESCRIBE:

____

3. HAVE YOU EVER BEEN INJURED IN THE PAST? ________________________
IF SO, PLEASE GIVE THE DETAILS:

A. NATURE OF INJURY: ____

B. DATE: ____

C. HOW WERE YOU INJURED? _______________________________________

D. WHERE? ____

E. NAME & ADDRESS OF EACH TREATING PHYSICIAN:
____

4. LIST BELOW WHAT NORMAL ACTIVITIES, INCLUDING SPORTS, HOBBIES, OR OTHER ACTIVITIES, YOU REGULARLY ENJOYED IN THE LAST THREE YEARS REGARDLESS OF WHETHER OR NOT YOU NOW PERFORM THOSE ACTIVITIES:

____

____

____

PRIOR CLAIMS

1. IF YOU WERE INVOLVED IN ANY TYPE OF ACCIDENT RESULTING IN A CLAIM MADE BY YOU, PLEASE STATE THE FOLLOWING:

A. WHEN & WHERE WAS EACH CLAIM OR SUIT MADE? _______________
____

B. TYPE OF CLAIM MADE: ____

C. NAME & ADDRESS OF ATTORNEY: __________________________________

D. WAS SUIT INSTITUTED? ____

E. AMOUNT OF SETTLEMENT OR VERDICT: _________________________

DATE CASE CLOSED: ____

OTHER EXAMINING PHYSICIANS

1. OTHER THAN AS STATED PREVIOUSLY, HAVE YOU EVER BEEN EXAMINED BY ANY PHYSICIAN FOR ANY OTHER REASON IN THE PAST TEN YEARS? IF SO, STATE THE NAMES AND ADDRESSES OF THE PHYSICIAN AND THE REASON FOR THE EXAM:

____

____

____

POLICE RECORD

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME? ______ YES ______ NO
IF SO, STATE:

DATE	PLACE	CHARGES	RESULT

____

2. IS THERE NOW OR HAS THERE EVER BEEN A RESTRICTION ON YOUR DRIVER'S LICENSE? ______ YES ______ NO

DETAILS: ____

CONCLUSION

IN COMPLETING THIS QUESTIONNAIRE, HAVE YOU THOUGHT OF ANY INFORMATION WHICH WE HAVE NOT ASKED WHICH MAY BE OF SOME ASSISTANCE TO US IN SERVING YOU/ IF SO, PLEASE STATE IT HERE, NO MATTER HOW SILLY, TRIVIAL OR EMBARRASSING IT MAY SEEM.

____

____

____

I HAVE READ THE ABOVE STATEMENTS
AND THEY ARE TRUE AND CORRECT.

____
CLIENT