LINDELL & LAVOIE, LLP PERSONAL INJURY CASE INFORMATION	**STATUTE OF LIMITATIONS:** **SOURCE:**
	Type of File:
	Attorney:
	Sign up Date:
	Date of Loss:

PERSONAL DATA

Name:	Marital Status:
Home address:	Spouse:
	Phone:
	Work Phone:
	Email:
Maiden Name:	Children or parents:
Address:	Phone:
DOB: Age:	DLN: State:
SSN:	Restrictions/endorsements:
OK to disclose?	
Emergency Contact:	Phone:
Address:	Alt Phone:

EMPLOYMENT

Employer:	Work Phone:
Address:	
Job description:	Date of Hire:
Rate of pay $ /hour hrs/week	Salary:
Commission:	Gross weekly wage:
Supervisors name:	Title:
Other employment/income:	Gross weekly wage:
Time lost from work:	NF paying:
Other employment/income:	Gross weekly wage:
Time lost from work:	NF paying:

EDUCATION/MILITARY

High school:	Post high school:
Additional schooling:	
Military:	

OTHER PERSONAL INFORMATION

Alcohol/drug abuse treatment:	
Facility:	Year(s):
Doctor:	Phone:
Address:	
Criminal Convictions:	

Court:	Charge:
Disposition:	Year(s):
Prior lawsuits/insurance claims:	
Describe:	

COLLATERAL SOURCE INSURERS

Health Insurer:	
Address:	
Group No.:	ID No.:
File/Claim No.:	
Contact:	Phone:
Disability Insurer:	
Address:	
Policy No.:	File/Claim No.:
Contact:	Phone:
Other Insurer(s):	
Address:	
Group No.:	ID No.:
File/Claim No.:	
Other Insurer(s):	
Contact:	Phone:
Address:	
Group No.:	ID No.:
File/Claim No.:	

VEHICLES – INSURANCE INFORMATION

Vehicle Year: _____ Make: _____	Model: _____ Color: _____
License No.:	State: Mileage:
Primary PIP company:	
Address:	Phone:
Adjuster:	Claim No.:
Stacking available:	Policy No.:
Owner of vehicle:	
Address:	
Coverage per	
PIP limits:	UM:
UIM:	PD:
Other occupants of client's vehicle:	
1. Driver (if not client):	Phone:
Address:	Alt Phone:
Relationship:	DOB:
DLN:	
2. Name:	Phone:
Address:	Alt Phone:
Relationship:	DOB:
DLN:	
3. Name:	Phone:
Address:	Alt Phone:

Relationship:	DOB:
DLN:	

ADVERSE PARTY INFORMATION

Defendant #1:	
Address:	Phone:
Vehicle Year: _____ Make _____	Model _____ Color _____
License No.	State _____
Insurance Carrier:	
Address:	Phone:
Adjuster:	Claim No.:
Policy Limits:	
Defendant #2:	
Address:	Phone:
Vehicle Year: _____ Make _____	Model _____ Color _____
License No.	State _____
Insurance Carrier:	
Address:	Phone:
Adjuster:	Claim No.:
Policy Limits:	

WITNESSES

1. Name:	Phone:
Address:	Alt Phone:
2. Name:	Phone:
Address:	Alt Phone:
3. Name:	Phone:
Address:	Alt Phone:

Describe any conversations or discussions at the scene of the accident with other driver, witnesses, passengers:

Other notes:

MEDICAL INFORMATION

Injuries (in order of severity):

Treating medical providers (in chronological order):

1. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
2. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
3. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
4. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
5. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
6. Name:	Type/Dr.:
Address:	# of visits:
Phone:	

Prior or subsequent medical providers (chronological – most recent first):

1. Treatment/reason/claim:	Year:
Medical Provider:	Phone:
Address:	
2. Treatment/reason/claim:	Year:
Medical Provider:	Phone:
Address:	
3. Treatment/reason/claim:	Year:
Medical Provider:	Phone:
Address:	

ACCIDENT FACTS

Date:	Time:
Departure location:	Destination:
Weather conditions:	Direction of travel:
Speed:	Lane:
Description:	
Police Officer:	Badge #:

Police Department:	Phone:
Citations/Charges:	
Physical Evidence:	
Location:	
Facts going to mitigating contributory negligence:	
Evidence/suspicion of drinking, drugs, meds?	

PROPERTY DAMAGE

Damage to your vehicle: $
Do you have photographs? Y / N

OTHER EXPENSES

List expenses:	Amount: