

**PERSONAL INJURY INTERVIEW SHEET**

D/INTERVIEW: \_\_\_\_\_ D/ACCIDENT: \_\_\_\_\_ TIME/ACCIDENT: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_ REF. BY: \_\_\_\_\_

**CLIENT:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: (H) \_\_\_\_\_

\_\_\_\_\_ PHONE: (C) \_\_\_\_\_

Best Time to Reach: Morning Afternoon Evening Any **E-MAIL** or (W): \_\_\_\_\_

**D/BIRTH:** \_\_\_\_\_ **SOC. SEC. #:** \_\_\_\_\_

**EMPLOYMENT INFO:** EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ DAYS OFF: \_\_\_\_\_

NORMAL HR. WORK WEEK: \_\_\_\_\_ RATE OF PAY: \_\_\_\_\_

MISSED TIME FROM WORK: \_\_\_\_\_ HEALTH INS.: \_\_\_\_\_

**CLIENT'S INSURANCE:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_

ADJUSTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PD ADJ: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

MP ADJ: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS TO SUBMIT BILLS FOR MP: \_\_\_\_\_

UM/UIMS\$ \_\_\_\_\_ MP\$ \_\_\_\_\_ COLL/COMP DED\$ \_\_\_\_\_

CLAIM #: \_\_\_\_\_ RENTAL: \_\_\_\_\_

**DEFENDANT:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DEFENDANT'S INSURANCE:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_

ADJ: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

B/I LIMITS: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

**LIABILITY:**            **ACCEPTED**                            **DENIED**                            **SPLIT%** \_\_\_\_\_

RECORDED STATEMENT:            **Π**    YES   NO                            **Δ**    YES   NO

POLICE DEPT: \_\_\_\_\_ **POLICE REPORT #:** \_\_\_\_\_

**PROPERTY DAMAGE:** \_\_\_\_\_

PHOTOS                       ESTIMATE                      BY: \_\_\_\_\_                      \$ \_\_\_\_\_

VEHICLE LOCATION: \_\_\_\_\_  INSPECTION                      BY: \_\_\_\_\_

BODY SHOP PREFERENCE: \_\_\_\_\_

**ACCIDENT DESCRIPTION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VERBAL STATEMENT BY DEFENDANT: \_\_\_\_\_

WITNESS                      NAME: \_\_\_\_\_                      PHONE: \_\_\_\_\_

**INJURIES:**

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL:**                      AMBULANCE:     Yes     No                      HOSPITAL:         Yes     No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIOR ACCIDENTS** (*Auto (A), Work Related (WC), Slip & Falls (SF)*):         Yes     No

Mo./Year: \_\_\_\_\_    Type: \_\_\_\_\_                      Injuries: \_\_\_\_\_

Mo./Year: \_\_\_\_\_    Type: \_\_\_\_\_                      Injuries: \_\_\_\_\_

Mo./Year: \_\_\_\_\_    Type: \_\_\_\_\_                      Injuries: \_\_\_\_\_

**\*\* CLIENT MUST PROVIDE US WITH LIST OF DOCTORS FOR LAST 10 YEARS\*\***

**PRIOR INJURIES/ILLNESSES:** (*Major Surgeries, Broken Bones, Diabetes, Cancer, etc...*)

\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT(S):** (*Family, Personal Friend, Neighbor, etc ...*)

NAME: \_\_\_\_\_    H/PHONE: \_\_\_\_\_    CELL: \_\_\_\_\_

NAME: \_\_\_\_\_    H/PHONE: \_\_\_\_\_    CELL: \_\_\_\_\_

**DEFENDANT #2:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**DEFENDANT'S INSURANCE:** \_\_\_\_\_ POLICY # \_\_\_\_\_

ADJ: \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

B/I LIMITS: \_\_\_\_\_ CLAIM # \_\_\_\_\_

**LIABILITY:**            **ACCEPTED**                            **DENIED**                            **SPLIT%** \_\_\_\_\_