HART & DAVID, LLP - CLIENT INFORMATION SHEET

Copy of ID and insurance card **Today's Date: _____/_____ /20_____**

***Date of Occurrence:**_____ ***Referred by:** _____

***Place of Occurrence:**_____

Statute of Limitations: _____ **Type of Case:** _____

CLAIMANT:

FIRST NAME: _____ MIDDLE:_____LAST:_____

ADDRESS:_____ APT.#_____

CITY:_____STATE:_____ZIP:_____ HOME#:(_____)_____

CELL #: (____) _____ EMAIL: _____

DATE OF BIRTH:_____/_____/_____SS#: _____-_____-_____

LICENSE/STATE ID#: _____

DECEASED/MINOR/DISABLED:

FIRST NAME: _____ MIDDLE:_____LAST:_____

ADDRESS:_____ APT.#_____

CITY:_____STATE:_____ZIP:_____ HOME#:(_____)_____

DATE OF BIRTH:_____/_____/_____ SS#: _____-_____-_____

MARITAL STATUS: Married* Single * Separated No. OF CHILDREN: _____ No. UNDER 18:_____

SPOUSES NAME:_____ CELL #: (_____)_____

EMERGENCY CONTACT:

NAME: _____ PHONE#: (____)_____ RELATIONSHIP:_____

EMPLOYER:_____ ADDRESS: _____

CITY:_____STATE:_____ZIP:_____ PHONE #: _____

OCCUPATION: _____ EMPLOYED SINCE: _____

TIME MISSED:_____ SALARY/HOURLY RATE: _____/per _____

INSURANCE INFORMATION:

MEDICAL INSURANCE: _____ POLICY NO.: _____

GROUP NO.: _____MEMBER ID NO.: _____

MEDICARE: YES / NO MEDICARE NUMBER:_____ PART: A/B

MEDICAID: YES / NO MEDICAID NUMBER:_____

Crash/Incident Report: _____ Citations? Y/N _____

Witnesses:

1. Name: _____ 2. Name: _____

Address: _____ Address: _____

_____ _____

Phone No: _____ Phone No: _____

Description of Incident: _____

_____

_____

_____

_____

_____

_____

Injuries: _____

_____

_____

_____

_____

Please List Medical Providers Relating To Your Injuries
(Ambulance, Emergency Room, Doctors, Chiropractor, Physical Therapy, X-rays, MRI, etc.)

1. Name: _____
   Address: _____
   _____
   Phone No.: _____Dates of Treatment:_____

2. Name: _____
   Address: _____
   _____
   Phone No.: _____Dates of Treatment:_____

3. Name: _____
   Address: _____
   _____
   Phone No.: _____Dates of Treatment:_____

***** If more medical providers, list on the back of this sheet*****

Past Injuries/Medical History:

_____
_____
_____
_____
_____

Defendant Info:

Name: _____ Phone: _____

Address: _____

Defendant Insurance Co.: _____

Policy Number: _____ Claim No.: _____

Plaintiff's Auto Insurance Co. and/or Work Comp:

CARRIER: _____ UM/UIM? Y/N
ADDRESS: _____ MED PAY? Y/N

CLAIM NO.: _____ PHONE: _____

ADJUSTER: _____ LIMITS? _____