STILES LAW

Thank you for choosing Stiles Law, LLC to represent you with regard to your personal injury claim. In our continuing efforts to provide you with quality and accurate representation, we ask that you provide us with the following information for our files.

Date: _____

I. CLIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Social Media Networking Site? ☐Yes ☐No

Drivers License Number: _____ State: _____

Marital Status: _____ Spouses Name *(If applicable)*: _____

How Did You Hear About Us? _____

IF YOU ARE A MINOR, Please complete the following:
Mother's Name: _____ Telephone: _____

Father's Name: _____ Telephone: _____

II. EMPLOYMENT INFORMATION

Employer: _____ Dates of Employment: _____

Job Title/Occupation: _____ Job Description: _____

Address: _____

Pay: ☐Salary $_____ or ☐Hourly $_____ Pay Period: ☐Weekly ☐Biweekly ☐Other

Number of Hours Worked Per Day: _____ Number of Days Worked Per Week: _____

Supervisor Name: _____ Phone Number: _____

Number of Days Missed Due To Injury *(If applicable)*: _____ ☐Days ☐Months ☐Weeks

Date Returned *(If applicable)*: _____ Light/Restricted Duty? ☐No ☐Yes

III. ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____

Location of Accident: _____

City: _____ State: _____ Zip: _____ County: _____

Weather: _____ Were you a ☐Driver ☐Passenger ☐Pedestrian ☐Other

Accident Report Number: _____ Officer's Name: _____

Officer's Badge Number: _____ Is There Property Damage? ☐No ☐Yes

Please Describe How The Accident Happened: _____

_____

_____

_____

_____

Do you have photos and/or videos of the property damage or injuries sustained? ☐No ☐Yes

Have you started a journal concerning the accident and the pain you have suffered? ☐No ☐Yes

IV. WITNESSES

If there were no witnesses to the accident skip to Section V.

Witness #1 Name: _____

Address: _____

Phone Number: _____

Witness #2 Name: _____

Address: _____

Phone Number: _____

Witness #3 Name: _____

Address: _____

Phone Number: _____

V. DEFENDANT'S INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Cell Phone: _____ Email: _____

VI. INSURANCE & VEHICLE INFORMATION

Vehicle #1: You were the ☐Owner ☐Driver ☐Passenger of Vehicle #1

Vehicle Plate Number: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN Number: _____

Driver's Name: _____

Driver's Address *(If you were not the driver):* _____

City: _____ State: _____ Zip: _____ County: _____

Owner's Name *(If different from the driver):* _____

Owner's Address *(If you are not the owner):* _____

City: _____ State: _____ Zip: _____ County: _____

Auto Insurance Company: _____ Name of Insured: _____

Policy Number: _____ Claim Number: _____

Does Your Policy Include Uninsured/Underinsured Coverage? ☐No ☐Yes

Do You Carry Medical Payments Coverage On Your Policy? ☐No ☐Yes

Are you covered by a healthcare plan? ☐No ☐Yes (*If so, please provide a copy of your insurance card)*

Health Insurance Coverage: _____ Carrier: _____

Policy/Subscriber ID Number: _____

Do you receive Medicaid or Medicare? ☐No ☐Yes (*If so, please provide a copy of your member card)*

Vehicle #2:

Vehicle Plate Number: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN Number: _____

Auto Insurance Carrier: _____ Name of Insured:_____

Policy Number: _____ Claim Number: _____

Has An Adjuster Been Assigned To The Claim? ☐No ☐Yes *(If so, please complete the following)*

Adjuster's Name: _____

Phone Number: _____ Email:_____

VII: INJURIES

Did You Go To The Hospital? ☐No ☐Yes Did They Take X-Rays? ☐No ☐Yes

Did You Go By Ambulance? ☐No ☐Yes Ambulance Service: _____

Injuries Sustained In The Accident: _____

_____

_____

_____

_____

Please List All Prior Injuries and/or Medical Conditions: _____

_____

_____

_____

_____

VIII: HOSPITALS

Please provide information for all hospitals for which you have received treatment pertaining to this accident.

Hospital #1: _____ Doctor's Name: _____

Date of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type *(Check all that apply)*: ☐ER ☐Admission ☐Outpatient ☐CT Scan ☐X-ray

Hospital #2: _____ Doctor's Name: _____

Date of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type *(Check all that apply)*: ☐ER ☐Admission ☐Outpatient ☐CT Scan ☐X-ray

IX: PHYSICIANS

Please provide information for all physicians for which you have received treatment pertaining to this accident

1) Facility: _____ Doctor's Name: _____

Specialty: _____ Phone: _____

Address: _____

First Visit: _____ Last Visit:_____

2) Facility: _____ Doctor's Name: _____

Specialty: _____ Phone: _____

Address: _____

First Visit: _____ Last Visit:_____

3) Facility: _____ Doctor's Name: _____

Specialty: _____ Phone: _____

Address: _____

First Visit: _____ Last Visit:_____

4) Facility: _____ Doctor's Name: _____

Specialty: _____ Phone: _____

Address: _____

First Visit: _____ Last Visit:_____

X. PROPERTY DAMAGE INFORMATION

If your vehicle sustained property damage please indicate the following

Present Location of Vehicle: _____ Is Your Vehicle Drivable? ☐No ☐Yes

Indicate The Condition Of Your Vehicle: ☐Excellent ☐Good ☐Fair ☐Poor

Describe The Damage To Your Vehicle: _____

_____

_____

Lienholder's Name *(If applicable):* _____Amount of Lien/Payoff: $ _____

Do You Have Before/After Photographs of Your Vehicle? ☐No ☐Yes