STROW LAW LLC

INCIDENT INFORMATION SHEET – PREMISES LIABILITY

CLIENT INFORMATION Date_____

Client Name:

Mr. Ms. or Mrs. Spouse's full name, if married: _____

_____

_____

Address City State/Zip Code

Home # _____ Work # _____

Cell # _____

E-Mail at home _____ E-Mail at work _____

Date of Birth _____ Social Security # _____

Driver's License # _____

Emergency Contact: Name: _____

Address: _____

Home # _____ Work# _____Cell# _____

Email: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father: _____ Telephone: _____

Mother: _____ Telephone: _____

ACCIDENT INFORMATION

Date of Incident: _____Time of Incident:_____AM or PM?

City of Incident: _____ County of Incident:_____

NAME OF DEFENDANT: _____

DEFENDANT'S ADDRESS: _____

WERE THE POLICE CALLED TO THE SCENE? Yes ____ No ____

WAS AN ACCIDENT OR INCIDENT REPORT FILED? Yes ____ No ____

UNDERSTANDING OF HOW THE INCIDENT OCCURRED:

_____

_____

_____

_____

_____

_____

EMPLOYMENT INFORMATION

IF YOU HAVE OR ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING:

Employer:

_____

Name Address

Your position or title: _____

Rate of Pay: $ _____ per hour or $ _____ yearly salary

How many hours do you normally work per week? _____

Dates missed from work to date: _____ to _____

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF THE LOCATION AND ITEMS INVOVLED IN YOUR OCCURRENCE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you supply us with pictures? Yes ___ No ___

WITNESSES

Were there independent witnesses? Yes ___ No ___

Please list the following with respect to any independent witnesses:

NAME: _____ Phone Number:_____

Address:_____

NAME: _____ Phone Number:_____

Address:_____

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail:

_____

_____

_____

Did you go to the hospital? Yes ____ No ____

Name of Hospital: _____

Did you go by ambulance? Yes ____ No____

Name of Ambulance Service _____

Did they take x-rays? Yes _____ No _____ Did they take MRI's? Yes _____ No _____

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No ____

If yes, please list all Doctors and medical facilities: Name, address and telephone number:

_____

_____

_____

_____

_____

_____

_____

HEALTH INSURANCE

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name/Address of Insurance Carrier:

_____

PPO, HMO, Medicaid, Medicare, other (please circle one) _____

Name of Policy Holder:

_____

Group Number, if known:

_____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No ____

If yes, please state, to whom given and when:

_____

_____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS

(Please DO NOT leave blank, if none, so state)

DATE: _____

NATURE OF ACCIDENT OR INCIDENT/INJURIES (work related, auto, medical negligence?)

_____

_____

REFERRAL INFORMATION

How were you referred to us? (Circle any applicable) _____

I am a previous client Office sign Web Site Radio TV Billboard Friend (please see below) Physician (please see below) Phonebook Other_____

If phonebook: name of book_____

Name/address/phone of person who referred you:

_____