Andrea Conarro

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Attorney

INTAKE FORM: PERSONAL INJURY

CONFIDENTIAL Attorney-Client Communication

I. CLIENT INFORMATION

Last Name:____________________________ First Name:___________________________
MI:________ Date of Birth:________________SSN________________________________
Street Address____
City:____ State:_________
Zip:_____________ Home Phone:____________________________ Work
Phone:_________________________________ Pager/Cell
Phone:_________________________ E-mail:_______________________________________

Spouse/Guardian:

Date of Birth: __________________ SSN:_____________________________
Child: ______________________________ DOB: ___________________________

Child: ______________________________ DOB: __________________________

Critical Deadlines:
____

City/Public Authority Involved? Yes /No

Notice of Claim Deadline:
____

Statute of Limitations:
____
Automobile Accident Client Interviewed By: _______________________

Date: __________________

Referral Source: ______________________________________

II. EMPLOYMENT INFORMATION

Employer: ____________________________________

Client's Occupation:______________________

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70 Choice Avenue
Dahlonega, GA 30533

Address:
____

Weekly/Biweekly Salary: ___________

Date Employment Commenced: ___________________

No. of Hours Worked Per Day: _________

No. of Day Worked Per Week Week:______________

Supervisor: ___________________________

Phone No.: ______________________________

Last Day Worked Before Accident:
____

Date Returned: _________________

Light/Restricted Duty?: ___________________________

How Long Were You Confined To Bed:
____

How Long Were You Confined Home:
____

Employer's Disability Carrier:
____

Address of Employer's Disability Carrier:
____

Disability Carrier's Policy No.:

Workers Compensation Carrier:
____

Address of Workers Compensation Carrier:
____

WCB Carrier Case No.:
____

III. EDUCATION

School Name:
____
Address:
____
Grade Level: _______________________________

IV. ACCIDENT INFORMATION

Date of Accident: ______________ Day: ______________ Time: ___________

Location Of Accident:
____

Client Was Traveling On What Street/Road:
____

Offending Vehicle Was Traveling On What Street/Road
____

Weather: ________________

Plaintiff's Position In Vehicle: _________________________

Accident Description:
____
____
____
____
____

Precinct: __________________

Accident No.: _________________________________

Officer's Name: ______________ Officer's Badge No.: _________________

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V. Diagram Of The Accident:

VI. WITNESSES

Witness #1 Name: ____
Address: ____
Phone Number: ____

Witness #2 Name: ____
Address: ____
Phone Number: ____

Witness #3 Name: ____
Address: ____
Phone Number: ____

VII. VEHICLE INFORMATION

Client was the ________________ in vehicle # 1 (Owner/Operator/Passenger).

Vehicle No. 1: (Host Vehicle)

Vehicle Plate No.: __________________________ Vehicle's Year: _________________________ Vehicle's Make: _____________________________
Vehicle's Model: ______________________ Vehicle's VIN #: ____
Owner's Name: ____

Owner's Address:
____
Leaseholder's Name:
____

Address:
____
Operator:
____
Address:
____
Carrier/Insurance Code: _________________

Address:
____

Policy Holder: __________________________________

Policy No.: ____________________________

Effective Date of Policy: _____________

Expiration Date of Policy: ____________________________

Vehicle No. 2:

Vehicle Plate No.: _______________________ Vehicle's Year: ______________________
Vehicle's Make: ________________________________ Vehicle's Model:
________________________ Vehicle's VIN_______________________________________

Owner's Name:
____
Owner's Address:
____
Leaseholder's Name:
____ Address:
____
Operator:
____
Address:
____
Carrier/Insurance Code: _________________

Address: ____

Policy Holder: _______________________________ Policy No.: __________________________ Effective Date of Policy: ____________ Expiration Date of Policy: __________________________

Vehicle No. 3:

Vehicle Plate No.: __________________________ Vehicle's Year: __________________________ Vehicle's Make: _____________________________ Vehicle's Model: ______________________ Vehicle's VIN #: ____

Owner's Name: ____

Owner's Address: ____

Leaseholder's Name: ____ Address: ____

Operator: ____

Address: ____

Carrier/Insurance Code: ________________

Address: ____

Policy Holder: __________________________ Policy No.: ______________________ Effective Date of Policy: ____________ Expiration Date of Policy: _______________

Medical Care ____

Injuries Sustained: ____
____

Emergency Care At Scene?

Ambulance: Yes/ No

VIII. Hospitals

____
Hospital:

____

Date Of Treatment: __________________ Date Of Discharge: ____________________
Address:
____

IX. Physicians

1. Doctor's Name: _______________________________________ Specialty:
____________________ Address:
____
Phone: _________________________________ First Visit: __________________________

2. Doctor's Name: _______________________________________ Specialty:
____________________ Address:
____
Phone: _________________________________ First Visit: __________________________

3. Doctor's Name: _______________________________________ Specialty:
____________________ Address:
____
Phone: _________________________________ First Visit: __________________________

Priors
____
___ Has the client ever been involved in an automobile or any other type of accident?
Yes No

If yes, complete the following: DOA: ______________ Place:
____
Description:____
____
Injuries
Sustained:____

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Attorney

____

List the medical providers who rendered treatment: ______________________________________

____ ________ Did the client commence a lawsuit? Yes No

If Yes, Please list the name and address of client's prior counsel: ____

List ALL past and current primary or treating physicians below.

1. Doctor's Name: ______________________________________ Specialty: ____________________ Address: ____
Phone: ____ First Visit: _________________________

2. Doctor's Name: ______________________________________ Specialty: ____________________ Address: ____
Phone: ____ First Visit: _________________________

3. Doctor's Name: ______________________________________ Specialty: ____________________ Address: ____
Phone: ____ First Visit: _________________________

Priors ____

Description: ____
____

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