CLIENT INTAKE - PERSONAL INJURY
**** PASSENGER ****

DATE:_____/_____/_____ FILE #:_____

NAME:_____
(FIRST) (MIDDLE) (LAST)

PRESENT ADDRESS:_____
(NUMBER) (STREET) (APT #)

_____
(CITY) (STATE) (ZIP)

PHONE:__(___)_____ __(___)_____
(HOME) (WORK)

YOUR DATE OF BIRTH:_____/_____/_____ SSN #_____

HEALTH, AUTO, EMPLOYMENT OR OTHER MEDICAL INSURANCE COVERAGE (include policy number, amount of deductible, if any):

_____

_____

EMPLOYMENT INFORMATION:

EMPLOYED BY:_____

SUPERVISOR'S NAME:_____
OCCUPATION:_____ SALARY:$ _____
(MONTH/WEEK)

STREET ADDRESS:_____
(NUMBER) (STREET) (SUITE #)

_____
(CITY) (STATE) (ZIP)

TELEPHONE NUMBER:_____

DID YOU LOSE/EXPECT TO LOSE TIME FROM WORK AS A RESULT OF ACCIDENT?

YES _____ NO _____

NUMBER OF DAYS MISSED OR APPROXIMATE NUMBER OF DAYS YOU EXPECT TO MISS:

_____.

ACCIDENT INFORMATION:

DATE OF ACCIDENT:_____ TIME:_____ A.M. _____ P.M._____

IF AUTO ACCIDENT WERE YOU:

DRIVER:_____ PASSENGER:_____ FRONT SEAT:_____ BACK SEAT:_____ BICYCLE:_____
PEDESTRIAN:_____ NUMBER OF PEOPLE IN THE VEHICLE:_____

PLACE OF ACCIDENT:_____

HOW DID ACCIDENT HAPPEN? DESCRIBE BRIEFLY:_____

_____

WHERE WERE YOU GOING? _____

PHOTOGRAPHS TAKEN AT THE SCENE OF VEHICLE? YES _____ NO _____
WERE POLICY CALLED? YES _____ NO _____

IF YES, WAS IT: HIGHWAY PATROL _____ METRO _____ NLV _____
WAS A REPORT TAKEN? YES _____ NO _____

TICKET GIVEN TO: YOU/YOUR DRIVER _____ OTHER DRIVER _____ NONE _____
CITATION CHARGED:_____

INJURY INFORMATION:

IF TAKEN TO HOSPITAL, NAME OF HOSPITAL:_____

IF TAKEN BY AMBULANCE, NAME OF AMBULANCE:_____

DESCRIBE YOUR INJURIES:_____

_____

IMPORTANT: ARE YOU PRESENTLY OR HAVE YOU EVER BEEN A MEDICARE/MEDICAID RECIPIENT? _____ YES _____ NO

TREATING PHYSICIAN(S), CHIROPRACTOR(S) OR PHYSICAL THERAPIST(S):

NAME ADDRESS

1. _____ _____

2. _____ _____

***** STOP HERE - TELL THE RECEIPTIONIST THAT YOU ARE FINISHED *****