Case # _____	Completed By: _____
Paralegal / Attorney: _____	English / Spanish / Bilingual
Companion:_____	Needs Contracts: YES / NO

AUTO ACCIDENT CHECK SHEET

_____ **vs.** _____

DATE CASE RECEIVED: _____ **REFERRAL BY:**_____
DATE OF ACCIDENT: _____ **POLICE AT SCENE:**_____
TIME OF ACCIDENT: _____ **ACCIDENT REPORT #:** _____
LOCATION OF ACCIDENT: _____
PLAINTIFF:
NAME: _____ D/Birth: _____
ADDRESS:_____ SS # : _____
CITY: _____ STATE:_____ ZIP:_____
TELEPHONE: (Home) _____ (Work) _____(Cell) _____
E-MAIL ADDRESS: _____
YOUR NEAREST LIVING RELATIVE: _____
THEIR ADDRESS: _____THEIR PHONE: _____

ALL SOCIAL MEDIA ACCOUNTS

FACEBOOK: _____ OTHER: _____

FACTS OF ACCIDENT: (Please give brief description of how the accident happened)

_____
_____
_____

INFORMATION NEEDED REGARDING YOUR VEHICLE INVOLVED IN THE ACCIDENT:

TYPE OF VEHICLE: _____ MAKE/YEAR: _____ COLOR: _____
DRIVERS LIC. #: _____ OWNERSHIP: _____
OWNER'S ADDRESS IF DIFFERENT: _____
ESTIMATE OF REPAIR: _____ CAR LOCATION NOW: _____
PHOTOS OF THE VEHICLE? _____ TAKEN BY WHOM AND WHEN: _____
WITNESSES AT SCENE:_____

AIR BAG: (Yes ❑ No ❑) **SEAT BELT:** (Yes ❑ No ❑) **HELMET:** (Yes ❑ No ❑)

PLAINTIFF'S AUTO AND/OR GROUP HEALTH INSURANCE INFORMATION:

YOUR CAR INSURANCE COMPANY: _____

OWNER'S INSURANCE COMPANY: _____

NAMED INSURED: _____

ADDRESS OF INS. CO. _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO: _____ DEDUCTIBLE: _____

PIP COV. : _____ PIP DEDUCTIBLE? Yes ❑ No ❑ AMOUNT _____

COLLISION: _____ UNDERINSURED (U.M.): _____

ADJUSTER: _____ CLAIM NO: _____

TEL: _____ FAX: _____

OTHER CARS IN YOUR HOUSE: _____

HAVE YOU NOTIFIED YOUR INSURANCE CARRIER ABOUT THIS ACCIDENT? Yes ❑ No ❑

GROUP HEALTH CARRIER: _____

POLICY # _____ GROUP NO._____

YOUR INJURIES AS A RESULT OF THIS ACCIDENT:

_____

_____

_____

HAVE YOU HAD PHOTOS TAKEN OF YOUR INJURIES? Yes ❑ No ❑

AMBULANCE: Yes ❑ No ❑ **NAME OF HOSPITAL**: _____

ADMITTED: Yes ❑ No ❑ **X RAY'S :** Yes ❑ No ❑ **LENGTH OF STAY**: _____

YOUR DOCTORS **THEIR ADDRESSES / PHONE NUMBER**

_____

_____

_____

REFERRED TO: _____

MEDICAL HISTORY PRIOR TO ACCIDENT: (List **ALL** hospitalizations, back injuries, surgeries, including births, etc.) _____

_____

_____

LIST ALL SPORTS PLAYED (currently or in the past): _____

HAVE YOU INCURRED OTHER EXPENSES AS A RESULT OF THIS ACCIDENT I.E. MILEAGE, PRESCRIPTIONS, HOUSE CARE, LAWN CARE, ETC.? _____

HISTORY:

SINGLE: ❑ MARRIED: ❑ DIVORCED: ❑ WIDOWED: ❑

SPOUSE'S NAME: _____

CHILDREN: NAME AGE

_____

_____

_____

_____

OTHER DEPENDENTS: _____

DOMESTIC DISPUTES/DIVORCES: _____

_____

LIST ALL CHILD SUPPORT LIENS: _____

LIST ALL YOUR ADDRESSES FOR THE PAST 10 YEARS: _____

_____

_____

HOW MANY YEARS LIVING IN FLORIDA: _____

EDUCATIONAL BACKGROUND:

SCHOOLS ATTENDED GRADUATED CERTIFICATES/DEGREES EARNED

_____

_____

_____

_____

EMPLOYMENT HISTORY: (List ALL employers for the present and past 20 years)

PRESENT EMPLOYER: _____

ADDRESS: _____

SUPERVISOR NAME: _____ TEL NO.: _____

POSITION HELD: _____ JOB DESCRIPTION: _____

DATE EMPLOYED: _____ RATE OF PAY: _____

DAYS MISSED FROM WORK: _____ WAGES LOST (IF KNOWN): _____

DATES OUT: _____

PREVIOUS EMPLOYER: _____

ADDRESS & PHONE: _____

POSITION HELD: _____ HOW LONG: _____RATE OF PAY: _____

PREVIOUS EMPLOYER: _____

ADDRESS & PHONE: _____

POSITION HELD: _____ HOW LONG: _____RATE OF PAY: _____

SELF EMPLOYED Yes ❑ No ❑ OTHER INCOME: _____

CAN YOU PROVIDE YOUR LAST FIVE YEARS TAX RETURNS? Yes ❑ No ❑

RECREATIONAL ACTIVITIES: _____

AS A RESULT OF THIS ACCIDENT HOW HAVE YOUR ACTIVITIES BEEN LIMITED: _____

_____

_____

LIST ALL PRIOR ACCIDENTS, INJURIES AND/OR "FENDER BENDERS": _____

_____

_____

_____

DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITION? Yes ❑ No ❑

Explain: _____

HAVE YOU EVER MADE A WORKERS COMPENSATION CLAIM? Yes ❑ No ❑

Explain: _____

HAVE YOU EVER MADE A SOCIAL SECURITY CLAIM? Yes ❑ No ❑

Explain: _____

HAVE YOU EVER MADE A MEDICARE/MEDICAID CLAIM? Yes ❑ No ❑

Explain: _____

HAVE YOU EVER MADE A DISABILITY CLAIM OF ANY KIND? Yes ❑ No ❑

Explain: _____

OTHER INFORMATION:

AT THE TIME OF THIS ACCIDENT, WERE YOU ON THE JOB? Yes ❑ No ❑

IF SO, ARE YOU MAKING A CLAIM FOR WORKER'S COMP. BENEFITS? Yes ❑ No ❑

ARE YOU COVERED UNDER ANY OTHER INSURANCE PROGRAM? Yes ❑ No ❑

DO AERIAL PHOTOS NEED TO BE TAKEN? Yes ❑ No ❑

WHAT WAS THE WEATHER AT THE TIME OF THE ACCIDENT?_____

WAS THE ACCIDENT COVERED BY THE NEWS MEDIA? Yes ❑ No ❑

IF SO, NAME OF MEDIA (newspaper, TV, etc.):_____

DEFENDANT:

NAME: _____

STREET ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO.: _____ LIMITS: _____

ADJUSTER: _____ PHONE: _____

CLAIM NO: _____ FAX: _____

OWNER OF CAR IF DIFFERENT FROM DRIVER: _____

STREET ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

OWNER'S INSURANCE CO.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

POLICY NO.: _____ LIMITS: _____

ADJUSTER: _____ PHONE: _____

CLAIM NO: _____ FAX: _____

WERE POLICE CHARGES MADE AGAINST DEFENDANT? Yes ❑ No ❑

MISC. INFORMATION: _____

_____

_____

_____