The Law Office of
Benjamin D. Brubaker
1485 Comer Road Comer, GA 30629
(706) 224-7329 • ben@benbrubakerlaw.com

CLIENT INFORMATION

Client Name:

Spouse's Full Name (if married):

Today's Date:

Date of accident:

Driver or Passenger?

Driver's Full Name (If You Were Passenger):

Spouse's full name, if married:

Physical Address City State/Zip Code:

Home Phone:

Cell Phone:

E-Mail:

Date of Birth:

Social Security:

Driver's License:

Emergency Contact Name and Phone Number:

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

Father Name:

Father Telephone:

Mother Name:

Mother Telephone:

ACCIDENT INFORMATION

Date of Incident:

Time of Incident:

City of Incident:

County of Incident:

Road/Intersection (if applicable):

WERE THE POLICE CALLED TO THE SCENE?

WAS AN ACCIDENT OR INCIDENT REPORT FILED?

PLEASE DESCRIBE HOW THE INCIDENT OCCURRED:

_____

_____

_____

_____

_____

_____

PASSENGERS/COMPANIONS (if applicable): (other people in the car who were injured):

Name:

Contact Number:

Address City State/Zip Code:

Date of birth:

Social Security Number:

Driver's License:

Spouse's Name, if Married:

Name:

Contact Number:

Address City State/Zip Code:

Date of birth:

Social Security Number:

Driver’s License:

Spouse’s Name, if Married:

Name:

Contact Number:

Address City State/Zip Code:

Date of birth:

Social Security Number:

Driver’s License:

Spouse’s Name, if Married:

DESCRIPTION OF INJURIES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did you go to the hospital?

Name of hospital:

Transported by ambulance?

Name of ambulance service

Did they take x-rays?

ARE YOU SEEING A DOCTOR NOW? (list all Dr.'s name/address/number)

_____

_____

_____

_____

Do you anticipate any loss of earnings, due to accident related injuries?

IF APPLICABLE: PROPERTY DAMAGE (Damage to your vehicle)

DO YOU NEED HELP IN RESOLVING THE DAMAGE TO YOUR VEHICLE?

IS YOUR VEHICLE DRIVABLE?

Estimated Damage to your Vehicle: $

WHERE IS YOUR VEHICLE LOCATED?

Your vehicle's year, make, model and color:

Your vehicle plate number:

Do your have clear title to your vehicle?

Who is the owner of your vehicle?

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you supply us with pictures of your vehicle?

IF NOT, Is your vehicle available for us to take pictures?

IF APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION
Name of your auto Insurance Carrier:

Name of Policy:

Policy Number:

Agent/Adjuster:

Telephone Number:

Claim Number (if known):

Type of Coverage:

PIP Limits: $

Holder:

DEFENDANT INFORMATION:

IF APPLICABLE AUTOMOBILE INSURANCE:

Driver's Name:

Telephone Number:

Address:

Driver's Date of Birth, if known:

Driver’s license number, if known:

Name of Insurance Carrier:

Agent/Adjuster:

Telephone Number:

Fax Number:

Policy Number (if known):

Claim Number:

DESCRIPTION OF DEFENDANT'S (other driver) VEHICLE:

Year, Make and Model:

Plate Number:

Owner's Name, if different from driver:

Were there passengers in the other driver's vehicle? If yes, how many?

Were there independent witnesses (individuals who were not involved in the accident who saw what happened?)

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 _____

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: name, address and telephone number

_____

_____

_____

_____

LOSS OF EARNINGS

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

Employer:

_____

Your position or title:

_____

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

How many hours do you normally work per week? _____

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

Name of Insurance Carrier:

_____ PPO, HMO,

Medicaid, other (please circle one)

Name of Policy Holder:

_____

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 (auto, work related, slip & fall, medical negligence?)

_____

_____

_____

How were you referred to us?_____

DO YOU CURRENTLY HAVE A WILL? Yes _____ No _____

HAVE YOU BEEN DENIED SOCIAL SECURITY BENEFITS? Yes _____ No_____

HAVE YOU BEEN DENIED VETERANS BENEFITS? Yes _____ No_____

DO YOU HAVE NEED LEGAL ASSISTANCE IN AN IMMIGRATION MATTER? Yes____ No_____