LAW FIRM OF

LAUB & LAUB

A Professional Corporation

PERSONAL INJURY
WORKERS COMPENSATION
CRIMINAL DEFENSE
BANKRUPTCY

Name: _____ Date:_____

Mailing Address: _____

Physical Address: _____

Home Ph (___)_____ Work Ph (___)_____ Cell Ph (___)_____

Email Address: _____ Emergency Ph (___)_____

Date of Birth: _____ SSN# _____

Circle One: Married / Single / Minor Spouse's Name _____

If Minor: Name / Phone # of parent if different from above _____

_____

Date of Accident: _____ Were you wearing a seat belt Y / N

Referred to our office by: _____

EMPLOYMENT INFORMATION

Employer: _____

Address: _____

Phone Number: _____ Job Title: _____

Time loss from work to date (if any) _____

Rate of pay: _____

☐ 1148 Ski Run Blvd.
South Lake Tahoe
California, 96150
(530) 577-LAUB
Fax (530) 544-4920

☒ 711 S. Carson St., Suite 2
Carson City
Nevada, 89701
(775) 883-LAUB
Fax (775) 883-1527

☐ 10368 Donner Pass Rd.
Truckee
California, 96161
(530) 587-LAUB
Fax (530) 587-2367

☐ 630 E. Plumb Lane
Reno
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(775) 323-LAUB
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ACCIDENT INFORMATION

Accident: Circle: rear end / head on / T-bone / side swipe

Other: _____

_____

_____

Day of the week _____ Time _____ a.m./p.m. City _____ State____

Road conditions: _____ Traffic controls: _____

Street you were traveling: _____ Direction: _____

Street of car causing accident: _____Direction: _____

Speed you were traveling: _____ mph Speed of other car: _____mph

Any alcohol or drugs taken by you within 12 hours before the accident:: _____

If you were the driver, did you have any passengers: Y / N If yes:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

POLICE REPORT

Were the police present at the scene: Y / N Name of agency _____

Report # _____ Anyone ticketed? Y / N Who: _____

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INSURANCE INFORMATION

Regarding the vehicle you were in, please circle: were you the driver / passenger in own / someone else's vehicle?

Your insurance company name: _____ Phone _____
Policy# _____ Claim # _____ Adjuster _____
Med. Pay amount $ _____ Uninsured/Underinsured amount _____
Property damage amount $ _____ Photo taken? Y / N By whom? _____
Where is your car now? _____

NAME OF PERSON CAUSING THE ACCIDENT AND THEIR INSURANCE, IF KNOWN:

Driver's Name: _____ Phone _____
Insurance company name: _____ Phone _____
Policy# _____ Claim # _____ Adjuster _____
Name of vehicle owner if different than driver _____

VEHICLE OWNER'S INSURANCE (IF NOT YOUR OWN VEHICLE)

Name of owner: _____ Phone _____
Insurance company name: _____ Phone _____
Policy# _____ Claim # _____ Adjuster _____

DO YOU HAVE HEALTH INSURANCE? Y / N

Name of company: _____ (provide copy of your ID card)

DO YOU HAVE SUPPLEMENTAL HEALTH INSURANCE? Y / N

Name of company: _____ (provide copy of your ID card)

Have you ever filed any prior Insurance claims (auto, workers comp, disability, etc.)?
Y / N If yes, please explain and when:

_____
_____
_____
_____

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If **NO** police present at the scene? Y / N If yes:

Name _____ Phone _____

Address_____ City _____

Name _____ Phone _____

Address_____ City _____

YOUR INJURIES

List **all** parts of your body injury in **this accident** and your symptoms:
(example: neck with sharp pain, tingling, numbness)

_____

_____

_____

_____

Please circle: right / left handed

Prior injuries you suffered in the last 5 years that required medical treatment: Y / N
If yes, please provide dates, type of injury (ies), treating physicians, current condition:

_____

_____

_____

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YOUR MEDICAL PROVIDERS FOR CURRENT ACCIDENT

NAME (DOCTOR, HOSPITAL, ETC) **PHONE**

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

Ambulance? Y / N If yes, name of ambulance/fire dept. _____

Transported where: _____

Care flight? Y / N If yes, name of company: _____

BELOW FOR ATTORNEY USE ONLY: INVESTIGATION

Pictures of: Injuries _____ PD _____ Accident scene _____ 3 PD estimates _____
Keep doctor appointments _____ Keep brief diary _____ Maintain records/receipts _____
Copy of Dec. Page _____ Witness Statements Immediately _____ Accident report _____
Other: _____

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