BABUN & TORRES, PA d/b/a
MIAMILEGALHELP.COM

Personal Injury/ Auto Accident

TODAY'S DATE: _____

REFERRED BY: _____

DATE OF ACCIDENT: _____

CLIENT'S NAME: _____

MAIDEN/PRIOR NAMES: _____

ADDRESS: _____

_____

HOME PHONE: _____ CELLULAR: _____

WORK: _____ OTHER: _____

FAX: _____ EMAIL: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

DRIVERS LICENSE #: (copy card) _____

SPOUSES NAME: _____

ADDRESS (if different from client's) _____

PHONE NUMBER(S): _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

SOCIAL SECURITY NO: _____

DATE/PLACE OF MARRIAGE: _____

CHILDREN (ALL THOSE WHO ARE DEPENDENT UPON YOU FOR SUPPORT)

NAME	SOCIAL SECURITY #	BIRTHDAY	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

BABUN & TORRES, P.A., MIAMILEGALHELP.COM
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Email: babuntorrespa@msn.com

PRESENT EMPLOYER: _____

ADDRESS: _____

JOB DESCRIPTION: _____ START DATE: _____

PAY PERIOD: _____ PAY AMOUNT: _____

TIME MISSED FROM PRESENT EMPLOYER: _____

IF NOT WORKING FOR PRESENT EMPLOYER AT TIME OF ACCIDENT,

THEN EMPLOYER: _____

ADDRESS: _____

JOB DESCRIPTION: _____ START DATE: _____

END DATE: _____ PAY AMOUNT: _____

TIME MISSED FROM EMPLOYER: _____

LOST WAGES DUE TO ACCIDENT: _____
Please explain:

_____

INCREASE OR DECREASE IN PAY SINCE YOUR ACCIDENT: Yes ____ No _____
If yes, please explain:

_____

HEALTH INSURANCE COMPANY: (copy card) _____

ADDRESS: _____

PHONE #: _____ ID #: _____ GROUP # _____

SUPPLEMENTAL INSURANCE COMPANY: _____
ADDRESS: _____
TELEPHONE NUMBER: _____
ID NUMBER: _____ GROUP NO: _____

DENTAL INSURANCE COMPANY: _____
ADDRESS: _____
TELEPHONE NUMBER: _____
ID NUMBER: _____ GROUP NO: _____

DATE OF ACCIDENT: _____

DAY OF WEEK: _____ TIME OF DAY: _____

WEATHER CONDITIONS: _____

LOCATION OF ACCIDENT: _____

_____

DESCRIPTION OF ACCIDENT: _____

_____

_____

STATE IN FULL DETAIL ALL INJURIES RECEIVED AS A RESULT OF THIS ACCIDENT:

_____

_____

_____

_____

DID YOU MAKE ANY TYPE OF REMARK TO ANY PERSON INVOLVED IN THE ACCIDENT OR ANY PERSON STANDING AROUND WATCHING? IF SO, WHAT DID YOU SAY AND TO WHOM:

_____

_____

_____

STATEMENTS MADE TO INVESTIGATOR, INSURANCE ADJUSTER OR OTHERS:

EXPLAIN:

_____

_____

_____

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DID YOU GIVE ANY WRITTEN STATEMENTS ABOUT THE INCIDENT?

EXPLAIN:

_____

_____

_____

DATE: _____

TO WHOM: _____

DID YOU SIGN IT: _____ DID YOU OBTAIN A COPY: _____

WHAT PERSONS WERE PRESENT: _____

ARE YOU AWARE OF ANY STATEMENTS MADE BY DEFENDANT, EITHER AT THE TIME OF THE ACCIDENT, OR WRITTEN OR ORAL AT ANY OTHER TIME.

_____

_____

_____

IF AUTO ACCIDENT: USING THE BACK OF THIS PAGE, DRAW A DIAGRAM OF THE ACCIDENT, INDICATING ON THIS DIAGRAM THE DIRECTION OF NORTH. INDICATING ON THIS DIAGRAM WHAT HAPPENED, GIVING THE NAME OF THE STREETS OR HIGHWAY NAMES OR NUMBERS, AND SHOW DIRECTION OF TRAVEL BY ARROWS. ALSO INDICATE THE DIRECTION OF NORTH BY PUTTING AN ARROW IN A CIRCLE.

IF SLIP AND FALL:

WHAT DID YOU SLIP AND FALL OVER/IN: _____

_____

_____

WHAT TYPE OF SHOES WERE YOU WEARING? : _____

WHAT TYPE OF CLOTHING WERE YOU WEARING? : _____

IF SLIP AND FALL: BRING SHOES YOU WERE WEARING TO THE OFFICE.

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TORTFEASOR

NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

POLICY NO: _____ CLAIM NO: _____

CITATION ISSUED: _____

SECOND TORTFEASOR

NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

DATE OF BIRTH: _____

DRIVERS LICENSE NUMBER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

POLICY NO: _____ CLAIM NO: _____

POLICE DEPARTMENT: _____

ADDRESS: _____

CASE NO: _____

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WITNESS NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

WITNESS NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

AUTO INSURANCE COMPANY: (copy card) _____

ADDRESS: _____

TELEPHONE NUMBER: _____

POLICY NUMBER: _____

COVERAGE:

PIP: _____ DEDUCTIBLE: _____

MED PAY: _____UM: _____ BI: _____

LIABILITY:_____

ADJUSTER: _____ CLAIM NO: _____

DESCRIPTION OF MOTOR VEHICLE YOU WERE IN/INVOLVED INA ACCIDENT:

_____

DESCRIPTION OF ALL OTHER VEHICLES IN HOUSEHOLD:

_____

_____

ANY OTHER INSURANCE POLICIES IN THE HOUSEHOLD:

_____

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MEDICAL HISTORY

AMBULANCE/ FIRE RESCUE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

HOSPITAL: _____

ADDRESS: _____

FROM: _____ TO: _____ COST $ _____

DOCTOR'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

TYPE OF TREATMENT: _____

DOCTOR'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

TYPE OF TREATMENT: _____

DOCTOR'S NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

TYPE OF TREATMENT: _____

OUT-OF-POCKET EXPENSES: (NAME AND ADDRESS TO WHOME OWED, AMOUNTS)

_____

_____

_____

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PLEASE DESCRIBE ANY OF YOUR USUAL ACTIVITIES THAT YOU CANNOT PERFORM, OR CAN ONLY PERFORM WITH DIFFICULTY SINCE THE ACCIDENT, SUCH AS CLIMBING STAIRS, IRONING, CUTTING GRASS, DANCING, LIFTING CHILDREN, ETC.

_____

_____

_____

_____

HAVE YOU EVER BEEN INVOLVED IN PRIOR ACCIDENTS (AUTO, SLIP/FALL, WORKERS COMPENSATION, ETC.)? IF SO, PLEASE COMPLETE THE FOLLOWING:

TYPE OF INCIDENT: _____

DATE OF INCIDENT: _____

LAWSUIT: YES _____ NO _____ ATTY? _____

LOCATION: (COUNTY & STATE): _____

TYPE OF INCIDENT: _____

DATE OF INCIDENT: _____

LAWSUIT: YES _____ NO _____ ATTY? _____

LOCATION: (COUNTY & STATE): _____

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