CONFIDENTIAL NEW CLIENT MATTER

Name:_____Today's date:_____Your Home Ph. No.:(____)_____

How did you find out about us?_____Which paper/magazine/client (if any):_____

Soc. Sec. No>:_____Occupation?_____Work Ph. No.: _____Ext.____

Home Address:_____City:_____State:_____Zip:_____

Mailing Address:_____City:_____State:_____Zip:_____

Email: _____

What is the best time to call at home:_____am/pm Can we call at work?_____yes_____no_____Best time to call:_____am/pm

Pager No.:(if any): (____)_____Mobile Phone: (if any): (____)_____Fax No.:(____)_____

In case of Emergency Contact: Name:_____Relationship:_____

Phone No.: (____)_____Address:_____

Your Employer's Name/Address:_____

Dr. Lic. No.: _____Single____Married____Widowed____Date of Birth:_____Age_____

Are you a member of any pre-paid legal plans? Yes___No___If yes, which one?_____

Spouse's Name:_____Soc. Sec. No.:_____Occupation:_____

Spouse's Employer's Name/Address:_____Work Ph. No.:_____

CHILDREN: 1._____Age:___2. _____Age:___ 3._____Age:____

Date of Accident:_____ Reported to Police on: _____ Police Case No: _____ Which Police Dept:_____

Injuries: _____ Did you go to the Hospital: _____ If so, what Hospital: _____

Have you treated with a Doctor: : _____ If so, Name Doctor: _____ Phone # of Doctor: _____

Have you discussed this matter with another attorney?_____Yes_____No. If yes, whom and when?_____

In a few words describe the accident: _____

_____

_____

I/we have filled out this questionnaire completely and accurately. I/we understand that a consultation with the attorney does not constitute retaining the firm or the attorney. I understand that the attorney will undertake no representation of me/us or have any obligation of any kind whatsoever unless I/we have signed a retainer agreement with the firm I/we understand that the law firm is relying on the information given in this form and at the consultations, and further that inaccurate and incomplete information may hurt my/our case, and further that if I/we intentionally provide the law firm with false or deceptive information, I/we may be subject to civil and/or criminal liability.

_____ _____

CLIENT CLIENT

PLEASE DO NOT FILL OUT BELOW THIS POINT

I/we have been informed that this law firm will not undertake representation of this matter until a retainer has been signed and a fee has been paid . Further I/we have been informed as to the critical dates in our case and the consequences of our not adhering to these dates and in particular

_____

Signed:_____ _____Dated:_____

PERSONAL INJURY INTERVIEW

Today's Date:_____ How did you hear about us?_____

Have you ever filed for Bankruptcy? _____

Name:_____ S.S. #:_____

Address:_____ Date of birth: _____

City:_____St:___Zip_____ Place of birth: _____

Phone #:_____Work:_____ Driver's Lic.#:_____

Email: _____

Spouse:_____

Children and ages:_____

Date of accident:_____ Time:_____

Summary of accident:

_____

_____

_____

_____

Type of injury:_____

Place of accident:_____

Witnesses (addresses and phone #'s):

_____

_____

Any statement given: Yes_____ No_____

To whom? (name, address and phone #):_____

Employer:_____ Phone #:_____

Address:_____ Rate of pay:_____

City:_____St:___Zip:_____

Lost wages because of injury: Yes_____ No_____

Date disability began:_____

Date returned to work:_____

Did accident occur during course of employment: Yes_____ No_____

Compensation carrier:_____

Private health insurance:_____

Address:_____ Phone #:_____

City:_____St:___Zip:_____ Policy #:_____

Automobile insurance carrier:_____

Policy #:_____

Policy limits:_____

Property damage:_____

Did you own a motor vehicle at the time of the accident? Yes_____ No_____

Year:_____ Make:_____ Model:_____

Insurance coverage:_____

Did you reside with a relative who owned a motor vehicle at the time of the accident?_____

Year:_____ Make:_____ Model:_____

Name of carrier:_____ Policy#:_____

Address:_____

City:_____St:____Zip:_____

Hospital emergency room? Yes_____ No_____

If by ambulance, give exact name and address of company: _____

_____

Name and address of hospital:_____

_____

Treating physicians and addresses:_____

_____

Any prior accidents? (If yes, need all dates, injured areas, names of doctors, attorneys and amounts of settlements.):_____

_____

_____

_____

What other expenses or losses have you incurred as a result of this accident?_____

_____

_____

DEFENDANT INFORMATION

Name:_____ Phone:_____

Address:_____

City:_____St:___Zip:_____

Their insurance carrier:_____

Address:_____

City:_____St:___Zip:_____

Were any citations issued for this accident? Yes_____ No_____

Who received the citation and what was the charge?:_____

_____

Case #:_____

Which police department was involved?_____

How many vehicles were involved in the accident?:_____

Name three (3) relatives or friends in which we may contact in case of an emergency:

Name:_____Phone #:_____

Name:_____Phone #:_____

Name:_____Phone #:_____

Was another attorney handling this case? Yes_____ No_____

If so, give full name, address and phone #:_____

_____

PLEASE ATTACH COPY OF ATTORNEY'S DISCHARGE OR YOUR DISCHARGE OF THE ATTORNEY.

Client signature:_____ Today's date:_____

IT IS IMPERATIVE THAT IF YOU CHANGE YOUR PHONE NUMBER OR YOUR ADDRESS TO NOTIFY US IMMEDIATELY.