

LAW OFFICES OF
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PERSONAL INJURY AUTOMOBILE ACCIDENT INTAKE FORM

CLIENT INFORMATION:

Date: _____ Referred by: _____

Full Name: _____

Full Street Address: _____

City/State/Zip: _____

County: _____ OK to phone at work? _____

Home Phone: _____ Work Phone: _____

Other Number(s): _____

Social Security Number: _____ DOB: _____

Race: _____ Gender: _____

Marital Status: _____ Spouse's Name: _____

Prior Accident's: _____ When? _____ Prior Disabilities? _____

Driver's License #: _____ State _____

Disability Information: _____

Military? Yes No Branch: _____ Sponsor's SSN: _____

Employer: _____

Position: _____ How Long: _____

Missed Time: _____ Rate per Hour: \$ _____ Avg hrs. Week _____

MINOR INFORMATION:

Guardian's Name: _____

SSN: _____ DOB: _____

ACCIDENT INFORMATION

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

City: _____ County: _____ State: _____

Was the Accident on Private Property _____ Was the Accident your fault _____

Citation _____ Type _____ DUI _____

Investigating Police Dept. _____

Officer's Name: _____ Badge # _____ Report _____

Did you go to the hospital or doctor _____

Briefly, how did the accident occur: _____

Also W/C? _____ Type of Collision? _____ Light/Sign (Circle)

Where Seated? _____

If passenger, who was driving vehicle? _____

Vehicle Owner (& Address) _____

Year of Vehicle _____ Make: _____ Model: _____

State/Tag # _____ Color: _____ Drivable? _____

Where is car located? _____

Collision Ins. ? _____ Rental Ins. ? _____ Lien? _____

Emergency Medical Services:

Date of Service: _____ Which EMS? _____

Treated at scene? _____ Transported from scene? _____

Treating Hospital: _____ DOS _____

Xrays Taken? _____ Admitted, or ER only? _____

Treatment received/diagnosis: _____

Account Number: _____

Client's Health Insurance Company: _____

Address: _____

**Medicare: ___ Yes ___ No Policy # _____

Deductible: _____ Group # _____

Has deductible been met? _____ Policy Holder: _____

Secondary Insurance (if any) _____

Address _____

We referred to: _____

Address: _____

Other Provider: _____

Address: _____ Phone: _____

DOS _____ Treatment Received: _____

Prescription Medication? _____

MEDICAL HISTORY/INJURY INFORMATION

A) Are you currently under a physicians treatment for any reason? If yes, who are you treating with and why?

B) Location of injuries in this accident:(low back, mid back, right side, left side, neck, left/right shoulder or arm, left/right leg or knee, headaches, stitches, broken bones, etc.)

C) What caused these injuries? (Head hit window, steering wheel, jerked forward from impact, etc?)

D) What treatment have you received for your injuries? (Cat scans, X-rays, stitches, MRI, etc.)

CLIENT'S AUTO INSURANCE INFORMATION

Insurance Carrier _____

Address: _____

Agent: _____ Policy: _____

Insured: _____ Claim # _____

Adjuster: _____ Phone # _____

UM/UIM Insurance Carrier: _____

OTHER PARTY'S INFORMATION

Full Name _____

Street/City/Zip: _____

County _____ Phone Number _____

DOB _____ SSN _____ Race _____ Gender _____

Year/Make/Model of Vehicle: _____

Color: _____ Tag # _____ Was Vehicle Towed? _____

Vehicle owner/ address: _____

Address: _____

Insurance Carrier _____

Agent: _____ Policy # _____

Insured: _____ Claim # _____

Adjuster: _____ Phone # _____

PIP Coverage available? _____ Amt Available\$ _____

ACCIDENT DESCRIPTION

A) Details of both parties actions at the time of the impact (stopped or slowing down for traffic, vehicle stalled in the roadway, at an intersection controlled by traffic signal or stop sign, who had the green light, who had the right of way, yielding into traffic, passing on the wrong side, etc.)

B) On what side of the street and in what direction was EACH vehicle traveling at the time of the impact?

C) Did you speak with the officer investigating the accident? If so, what did you tell him?

D) Were there any passengers in either vehicle? If so, were they injured also?

E) Did you speak with the person who hit you? If so, what was the basis of the conversation?

F) Were there any independent witnesses to the accident? Did they speak to the officer?

Names/Numbers for statements:

G) Have you been contacted by the insurance adjuster concerning the accident? If so, which company was the adjuster with? What did you tell him? Did you give a recorded statement? Adjuster's name:

PROPERTY DAMAGE

- A) Location and degree (\$) of property damage to client's vehicle?

- B) Location and degree (\$) to other party's vehicle?

- C) Was either vehicle towed from the scene? Of so, which vehicle?

- D) Has an appraisal been done of the damage either at the garage or by an insurance adjuster? If so, where was the appraisal done and what was the amount?

- E) Was there any personal property damage in this accident? If so, what was damaged, owner, and approximate value:

LAW OFFICES OF JOENATHAN S. CHAPLIN

Joenathan S. Chaplin

-ATTORNEY AND COUNSELOR AT LAW-

4511 NORTH MAIN STREET

COLUMBIA, SOUTH CAROLINA 29203

Telephone: (803) 754-5600 Facsimile: (803) 691-8229

MEDICAL AUTHORIZATION AND PATIENT REQUEST FOR CONFIDENTIAL TREATMENT OF MEDICAL INFORMATION

DATE:

PATIENT:

TO:

You are hereby authorized and directed to permit the examiner of, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by my attorney or such person as he may authorize, all or any portion as desired by him of the following:

- A. Hospital records, x-rays readings and reports, laboratory records and reports, all tests of any type, character and reports thereof, statement of charges, and any history, condition, treatment, diagnosis, prognosis, etiology or expense;
- B. Medical records, including patient record cards, x-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, statement of charges, any and all of my records pertaining to the medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

You are further authorized and directed to furnish oral and written reports to my attorney, or his delegate, as requested by him on any of the foregoing matters.

By reason of the fact that such information as you have acquired as my physician or surgeon is confidential and requested not to furnish any such information in any form to anyone, without written authorization from me.

I also authorize my attorneys or their delegate to photograph my person while I am present in any hospital. I further authorize the sending of medical and hospital bills to my attorney.

Authorized Signature: _____

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CONTINGENT FEE AGREEMENT

hereinafter called "Client," does hereby employ and retain Law Offices of Joenathan S. Chaplin, hereinafter, called "Attorney" to represent Client as legal counsel on the following terms and conditions:

1. Attorneys will devote their full professional abilities to the case and Client agrees to fully cooperate with Attorneys. Neither party will settle the case without the other's approval. Attorneys may, in their absolute discretion, withdraw at any time from the case, if, after investigating, the claim does not appear recoverable to them, if there is no insurance coverage or if the costs and time required to bring the action are disproportionate to the likely recovery.
2. Client will pay Attorneys 33 1/3% of any settlement obtained if the case is settled at any time prior to the institution of a suit, and 33 1/3% of any settlement, or recovery obtained after instituting suit, and 33 1/3% of any recovery from a jury verdict and, will further pay the costs and expenses referred to in Paragraph 3 hereafter. If an appeal is taken, the client shall pay 40% of the judgment or settlement. **IN THE EVENT OF NO RECOVERY, CLIENT SHALL OWE ATTORNEYS NOTHING FOR SERVICES RENDERED OR LITIGATION COSTS.**
3. Client agrees that if recovery is made, Attorneys are authorized to deduct their fee and such costs from any proceeds recovered. Client authorizes and directs Attorneys to deduct any doctor, hospital, expert, or medical creditor of Client.
4. **CLIENT AGREES THAT ATTORNEYS HAVE MADE NO PROMISES OR GUARANTEES REGARDING THE OUTCOME OF CLIENT'S CLAIM.**
5. The Client agrees that the Attorney shall have a first lien against any settlement, award, or other proceeds incurred or due in the representation of Client.
6. Client does hereby bind his/her heirs, executors and legal representatives to the terms and conditions set forth herein.

I have read the agreement, have received a copy of it, and agree to the terms and conditions. There are no other agreements, oral or otherwise, between Client and Attorneys.

Dated: _____

CLIENT

JOENATHAN S. CHAPLIN

CLIENT

ATTORNEY