

# Quintilone & Associates

## PERSONAL INJURY QUESTIONNAIRE

PERSONAL AND CONFIDENTIAL

1. Name: \_\_\_\_\_ Date: \_\_\_\_\_
2. Home Address: \_\_\_\_\_
3. City: \_\_\_\_\_
4. Home Telephone: \_\_\_\_\_
5. Email: \_\_\_\_\_
6. Secondary phone (i.e. cell): \_\_\_\_\_
7. Alternate phone (i.e. work, pager, etc.) \_\_\_\_\_
8. Person to contact if you are unavailable, Name: \_\_\_\_\_
9. Telephone: \_\_\_\_\_
10. Who referred you to our office? \_\_\_\_\_
11. Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_
12. Present Employer: \_\_\_\_\_
13. Type of Business: \_\_\_\_\_
14. Address of Employer: \_\_\_\_\_
15. City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_
16. Starting Date \_\_\_\_\_ Present Position: \_\_\_\_\_

### **PERSONAL INJURIES**

INJURIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHOTOGRAPHS OF INJURIES? YES \_\_\_ OR NO \_\_\_

IF SO, PLEASE PROVIDE COLOR COPIES.

DID YOU VISIT A DOCTOR/CLINIC? YES \_\_\_ OR NO \_\_\_

NAME OF DOCTOR/CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATES SEEN: \_\_\_\_\_

TREATMENT PROVIDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DID YOU VISIT A HOSPITAL? YES \_\_\_\_\_ OR NO \_\_\_\_\_

NAME OF HOSPITAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DATES SEEN: \_\_\_\_\_

TREATMENT PROVIDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WILL YOU REQUIRE FUTURE CARE/TREATMENT? YES \_\_\_\_\_ OR NO \_\_\_\_\_

IF YES, PLEASE DESCRIBE FUTURE CARE/TREATMENT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TOTAL AMOUNT OF MEDICAL EXPENSES DUE TO INCIDENT: \_\_\_\_\_

LOSS OF EARNINGS: YES \_\_\_ OR NO \_\_\_ HOURLY WAGE: \_\_\_\_\_

PLEASE ESTIMATE AMOUNT:

### **YOUR INSURANCE INFORMATION**

POLICY NUMBER: \_\_\_\_\_

NAME OF INSURANCE AND/OR AGENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

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PHONE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

OFFICE WHERE INCIDENT WAS REPORTED: \_\_\_\_\_

TO WHOM WAS INCIDENT REPORTED? \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_

**FACTS ABOUT THE INCIDENT**

DATE OF INCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_

WAS INCIDENT ON PRIVATE PROPERTY? YES \_\_\_ or NO \_\_\_

NUMBER OF PEOPLE INVOLVED: \_\_\_\_\_ FATALITY: YES \_\_\_ or NO \_\_\_

DESCRIBE INCIDENT: \_\_\_\_\_

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TO WHOM WAS INCIDENT REPORTED? \_\_\_\_\_

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ANY PHOTOGRAPHS AND/OR ESTIMATES? YES \_\_\_ or NO \_\_\_

IF SO, PLEASE PROVIDE COLOR COPIES.

**INFORMATION ABOUT THE OTHER PARTY**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

INJURIES: \_\_\_\_\_

PHOTOGRAPHS OF INJURIES? YES \_\_\_ OR NO \_\_\_

IF SO, PLEASE PROVIDE COLOR COPIES.

**INSURANCE INFORMATION**

POLICY NUMBER: \_\_\_\_\_

NAME OF INSURANCE AND/OR AGENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**WITNESS INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**ADDITIONAL INFORMATION**

Have you consulted any other attorneys about this matter? \_\_\_\_\_

Name(s) and telephone number(s): \_\_\_\_\_

\_\_\_\_\_

Have you ever filed any case or charges or made any claim against this potential defendant (other than anything stated above in this questionnaire)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been involved in any legal dispute, insurance claim, accident claim, lawsuit or anything similar not described above? \_\_\_\_\_

If Yes, Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If we accept a case for you, what do you hope to accomplish? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there any other information that you think is pertinent? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_