Quintilone & Associates

PERSONAL INJURY QUESTIONNAIRE

PERSONAL AND CONFIDENTIAL

PERSONAL INFORMATION

NAME: ________________________________ DATE OF BIRTH: ___________________

SOCIAL SECURITY: _________________

DRIVER'S LICENSE: _________________

ADDRESS: ____

____

HOME PHONE: _______________________ CELL PHONE: _____________________

E-MAIL: _______________________

EMPLOYMENT INFORMATION

NAME: ____

ADDRESS: ____________________________________

____

WORK NUMBER: _______________________________

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: ____

LOSS OF EARNINGS: YES ___ OR NO ____ HOURLY WAGE: ____________

PLEASE ESTIMATE AMOUNT:

VEHICLE INFORMATION

MAKE: ____________ MODEL: ____________

YEAR: _______ COLOR:_________

LICENSE PLATE: _____________

DESCRIBE PROPERTY DAMAGE: ____

____

CAN YOU DRIVE VEHICLE? ________

ADDRESS WHERE VEHICLE IS LOCATED: ________________________________

____

PHONE: __________________

NAME OF REGISTER OWNER (if different from above): _______________________

ADDRESS: ____

____

PHONE: ___________________

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? ____________

DOES REGISTER OWNER HAVE INSURANCE? _____________

IF SO, PLEASE PROVIDE BOTH POLICIES:

DRIVER'S INSURANCE INFORMATION:

POLICY NUMBER: ____________________

NAME OF INSURANCE AND/OR AGENT: _________________________________

ADDRESS: ____

____

PHONE: ________________________

NAME OF INSURED: ____________________________

OFFICE WHERE ACCIDENT WAS REPORTED: _____________________________

TO WHOM WAS ACCIDENT REPORTED? ____________________

CLAIM NUMBER: _____________________________

REGISTER OWNER INSURANCE INFORMATION:

POLICY NUMBER: ___________________

NAME OF INSURANCE AND/OR AGENT: ________________________________

ADDRESS: ____

____

PHONE: _______________________

NAME OF INSURED: ___________________________

OFFICE WHERE ACCIDENT WAS REPORTED: ____________________________

TO WHOM WAS ACCIDENT REPORTED? ____________________

CLAIM NUMBER: _____________________________

PASSENGER INFORMATION

PASSENGER 1

NAME: ____________________________ DATE OF BIRTH: ________________

SOCIAL SECURITY: _______________

DRIVER'S LICENSE: _______________

ADDRESS: ___________________________________

____

HOME PHONE: ____________________ WORK PHONE: __________________

E-MAIL: ____________________ CELL PHONE: __________________

INJURIES: ____

____

PHOTOGRAPHS OF INJURIES? YES ___ OR NO ____

IF SO, PLEASE PROVIDE COLOR COPIES.

DID YOU VISIT A DOCTOR/CLINIC? __________

NAME OF DOCTOR/CLINIC: ________________________________

ADDRESS: ____

____

PHONE: ____________________________________

LOSS OF EARNINGS: YES ___ OR NO ____

PASSENGER 2

NAME: ____________________________ DATE OF BIRTH: ________________

SOCIAL SECURITY: ________________

DRIVER'S LICENSE: ________________

ADDRESS: ___________________________________

____

HOME PHONE: ____________________ WORK PHONE: ___________________
E-MAIL: ____________________ CELL PHONE: ___________________

INJURIES: ____

____

PHOTOGRAPHS OF INJURIES? YES ___ OR NO ____

IF SO, PLEASE PROVIDE COLOR COPIES.

DID YOU VISIT A DOCTOR/CLINIC? __________

NAME OF DOCTOR/CLINIC: ________________________________

ADDRESS: ____

____

PHONE: ____________________________________

LOSS OF EARNINGS: YES ___ OR NO ____

PASSENGER 3

NAME: ____________________________ DATE OF BIRTH: ________________

SOCIAL SECURITY: ________________

DRIVER'S LICENSE: ________________

ADDRESS: ____________________________________

____

HOME PHONE: _____________________ WORK PHONE: ___________________
E-MAIL: _____________________ CELL PHONE: ___________________

INJURIES: ____

____

PHOTOGRAPHS OF INJURIES? YES ___ OR NO ____

IF SO, PLEASE PROVIDE COLOR COPIES.

DID YOU VISIT A DOCTOR/CLINIC? __________

NAME OF DOCTOR/CLINIC: _________________________________

ADDRESS: ____

____

PHONE: _____________________________________

LOSS OF EARNINGS: YES ___ OR NO ____

FACTS ABOUT THE ACCIDENT

DATE OF ACCIDENT: ___________________ TIME: _______________

LOCATION (Nearest Street or Highway): ____

____

CITY: _______________________ COUNTY: _______________________________

WAS ACCIDENT ON PRIVATE PROPERTY? YES __ or NO ___

NUMBER OF VEHICLES INVOLVED: _______ FATALITY: YES __ or NO ___

DESCRIBE ACCIDENT: ____

____

____

____

____

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: ________________

DRIVER'S LICENSE: ________________

ADDRESS: _____________________________________

____

HOME PHONE: ______________________ WORK PHONE: ___________________

E-MAIL: ______________________ CELL PHONE: ___________________

INJURIES: ____

____

PHOTOGRAPHS OF INJURIES? YES ___ OR NO ____

IF SO, PLEASE PROVIDE COLOR COPIES.

VEHICLE INFORMATION

MAKE: ____________ MODEL: ____________

YEAR: _______ COLOR:_________

LICENSE PLATE: _____________

INSURANCE INFORMATION

POLICY NUMBER: ____________________

NAME OF INSURANCE AND/OR AGENT: __________________________________

ADDRESS: ____

____

PHONE: _________________________

WITNESS INFORMATION

NAME: ___________________________________

ADDRESS: ____

____

PHONE: _________________________

NAME: ___________________________________

ADDRESS: ____

____

PHONE: _________________________