

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: _____

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: _____

TO WHOM WAS INCIDENT REPORTED? _____

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? _____
