**Quote:** _____
**Down Payment:** _____
**Payment Plan:** _____
**Attorney Initials:** _____

# PERSONAL INJURY/ CAR ACCIDENT IN-TAKE FORM

Name: _____

Address: _____

D.O.B: _____

Phone: _____

Date of Accident: _____

S. O. L. : _____ (office use only)

Law enforcement agency on scene: _____

Did you get the officers card: __Y/N_: Name: _____

Was your vehicle towed? _____

Was anyone in the vehicle with you: Y/N

Were they injured: Y/N -**claim will have to be submitted for each person injured in the car**

Did you go the Hospital Y/N By Ambulance: Y/N

Name of Ambulance Service: _____

Have you filed a claim on your insurance: Y/N

Name of YOUR Insurance Company: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

Name of Adjuster: _____

Have you filed a claim on the other parties Insurance: Y/N

Name of OTHER PARTIES Insurance Company: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

Name of Adjuster: _____

**LIST OF PROVIDERS:**

Please name every medical provider you have seen as a direct result of this accident including but not limited to: Ambulance Services, Emergency Room, Urgent Care, Chiropractic care, or any other medical provider.

1: _____

2: _____

3. _____

4. _____

5. _____

6. _____

7. _____

**SUBROGATION:**

Do you have Health Insurance? Y/N

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____

**** FOR IN-OFFICE USE ONLY:**

Consultation notes:_____
_____
_____
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