LAW OFFICES OF DIANNE SAWAYA LLC

PERSONAL INFORMATION

Today's Date:	Who can we thank for your referral to our office?
Name:	
Date of Birth:	SSN:
Phone:	Permission to send text messages to you? Yes ☐ No ☐
Current address:	Apt:
City:	State:	ZIP Code:
Email:	Are you a Veteran? Yes ☐ No ☐ *(If so, **Thank you** for your service)*
Marital status:	Spouse's name:

Please complete the following section regarding your Social Media Accounts **This information is for internal use and will be kept private.*

Facebook: Yes ☐ No ☐	Username:	
Snapchat: Yes ☐ No ☐	Instagram: Yes ☐ No ☐	Twitter: Yes ☐ No ☐

INFORMATION ON THE ACCIDENT

Date:	Time:	Location:
What was this trip for work purposes? Yes ☐ No ☐	Did anyone take photographs at the accident scene? Yes ☐ No ☐	

Please describe the accident, include weather and road conditions:

Did an ambulance come to the scene? Yes ☐ No ☐	Ambulance Name:
Were you transported to the hospital? Yes ☐ No ☐	Hospital Name:
Did the Fire Department come to the scene? Yes ☐ No ☐	Fire Department Name:
Were there other people in either vehicle? Yes ☐ No ☐	Were they injured? Yes ☐ No ☐
Were the police notified? Yes ☐ No ☐	Did the police respond to the scene? Yes ☐ No ☐
Which Police Department/City?	Case #:
Were **you** issued a ticket/summons? Yes ☐ No ☐	Was **the other driver** issued a ticket/summons? Yes ☐ No ☐

Were you under the influence of alcohol or drugs at the time of the accident? Yes ☐ No ☐

In your opinion, was the other driver under the influence of alcohol or drugs? Yes ☐ No ☐

In your opinion, was the other driver using their cell phone at the time of the accident? Yes ☐ No ☐

Did you make any statements to anyone? Yes ☐ No ☐	To Whom?

What did you say?

Did anyone make any statements to you? Yes ☐ No ☐	Who?

What did they say?

Including both inside and outside of the vehicles involved, were there any witnesses to the accident? Yes ☐ No ☐

Name:	Phone Number:
Name:	Phone Number:
Name:	Phone Number:

EMERGENCY CONTACT

Name of a relative or friend not residing with you:

Relationship:	Phone:

HEALTH INSURANCE

Do you have HEALTH INSURANCE? Yes ☐ No ☐

Name of Insurance Company:

Name of employer providing coverage:

Group/Policy Number:	Member Number:

***If you currently do **not** have a policy, but **did** you have one at the time of the accident

Name of Insurance Company:

Name of employer providing coverage:

Group/Policy Number:	Member Number:

Does **MEDICARE** pay any of your medical bills? Yes ☐ No ☐	Medicare Number:
Does **MEDICAID** pay any of your medical bills? Yes ☐ No ☐	Medicaid Number:
Are you eligible to receive treatment at a **VA Hospital**? Yes ☐ No ☐	
Do you receive **Social Security**? Yes ☐ No ☐	If yes: SSR ☐ SSDI ☐ SSI ☐

INFORMATION ABOUT THE VEHICLE <u>YOU</u> WERE IN

Vehicle make and model:	Who owns the vehicle?
Position in vehicle:	Were you wearing a seat belt? Yes ☐ No ☐
Describe the damage to the vehicle you were in:	
Was the vehicle drivable? Yes ☐ No ☐	Was the vehicle towed from the scene? Yes ☐ No ☐
Were damage estimates prepared on the vehicle you were in? Yes ☐ No ☐	
By Whom?	Amount of estimated damage:
Has the vehicle been repaired? Yes ☐ No ☐	Who repaired it?
Do you have photographs of the damage to your vehicle? Yes ☐ No ☐	

INFORMATION ABOUT <u>YOUR</u> AUTOMOBILE INSURANCE

Is your car insured? Yes ☐ No ☐	Have you notified your insurance company? Yes ☐ No ☐
Name of your insurance company:	Phone Number:
Policy Number:	Claim Number:
Name of your agent, adjuster or team working with you:	
Do you have Medical Payment Coverage? (Medpay) Yes ☐ No ☐	Amount Available:
Do you have Uninsured/Underinsured Motorist Coverage? Yes ☐ No ☐	Limits:
Do you have any other vehicles in your household? Yes ☐ No ☐	
If yes, are those vehicles insured by a policy other than the one noted above? Yes ☐ No ☐	
If yes, which company and policy number?	
Do you live with any family members who have their own auto insurance policies? Yes ☐ No ☐	
If yes, please state the name of the family member, relationship to you, company, policy number?	

IF YOU WERE A <u>PASSENGER</u> **Please complete section above as well as section below

Who was driving?	Who owns the car?
Is the driver's car insured? Yes ☐ No ☐	Has the driver notified his/her insurance? Yes ☐ No ☐
Name of driver's insurance company:	Phone Number:

Policy Number:	Claim Number:
Name of agent or adjuster working on claim:	
Does the driver's auto insurance have Medical Payment coverage? Yes ☐ No ☐	Amount Available:
Does the driver's auto insurance have Uninsured/Underinsured coverage? Yes ☐ No ☐	Limits:
INFORMATION ABOUT THE OTHER DRIVER'S AUTOMOBILE INSURANCE	
Is the driver's car insured? Yes ☐ No ☐	Have they notified their insurance? Yes ☐ No ☐
Name of his/her insurance company:	Phone Number:
Policy Number:	Claim Number:
Name of agent or adjuster working on claim:	
Bodily Injury policy limits on his/her auto insurance:	
Have you been contacted by his/her insurance company? Yes ☐ No ☐	
Any letters received requesting information or signatures? Yes ☐ No ☐	
Has anyone taken your recorded statement? Yes ☐ No ☐	If so, who and when?
INFORMATION ABOUT THE OTHER VEHICLE AND/OR DRIVER	
Vehicle make and model:	Who owns the vehicle?
Who was driving?	Phone Number:
Driver's Address:	Apt #:
City: State:	ZIP Code:
Describe the damage to the other vehicle:	
Do you have photographs of the damage to the other vehicle? Yes ☐ No ☐	
Was the vehicle drivable? Yes ☐ No ☐	Was the vehicle towed from the scene? Yes ☐ No ☐
Is the vehicle a company vehicle? Yes ☐ No ☐	
Company Name:	Company Phone:
Company's Address:	Unit/Suite #:
City: State:	ZIP Code:

Was the other vehicle a:		
	Government vehicle, such as a bus?	Yes ☐ No ☐
	Corporate or Commercial vehicle, such as a delivery truck?	Yes ☐ No ☐
	Construction equipment, such as a dump truck?	Yes ☐ No ☐

INFORMATION ABOUT YOUR INJURIES

Please list any bruises, cuts or other visible injuries and please also list any medical complaints or symptoms you think may have been **caused by** the accident (*please include both physical and psychological injuries, complaints and/or symptoms)*:

Do you have pictures of any visible injuries? Yes ☐ No ☐

Did you hit your head or any other body party on anything in the accident? Yes ☐ No ☐ If yes, please describe:

Did you lose consciousness? Yes ☐ No ☐	For how long?

If you don't think you lost consciousness, is there anything about the accident you don't recall (such as time of the accident, taking off your seat belt) Yes ☐ No ☐ If yes, please describe:

Please list the names of all medical facilities you've been to since the time of the accident.

Facilities	Full Name	Date	Phone Number/Address
Emergency Dept:			
Hospital:			
Walk-in Clinic:			
Urgent Care:			
Doctor			
Chiropractor:			
Physical Therapist:			
Other:			

Please list any treatment you have had to the same or similar body parts before this accident. **Please include date(s) of the treatment, type, length and medical professional performing treatment.*

Please list any surgeries you have had before the accident. **Please include the date, type of surgery, doctor and hospital surgery performed at.*

Please list any PAST motor vehicle accidents you've been in, any Workers' Compensation claims you have filed, or claims of any other sort you've made: **Please include year of accident, injuries sustained, and treatment received.*

Employment Information			
Were you on the job at the time of the accident? Yes ☐ No ☐			
Employer's Name:		Your Occupation:	
Employer address:			
City:		State:	ZIP Code:
Phone:		Income at the time of the accident: Per	
Any other income (commissions, bonuses, second job etc.): $			
Income now: Per		Any other income (commissions, bonuses, second job etc.): $	
Has this accident affected your ability to do your job? Yes ☐ No ☐		Are you working now? Yes ☐ No ☐	
As a result of this accident, have you missed any time from work? Yes ☐ No ☐			
Note the period of time for work missed:			
Were you provided a work excuse from a medical professional? Yes ☐ No ☐			
Name of the doctor who told you not to work:			
Doctor's address:			Phone:
City:	State:		ZIP Code:
Are you receiving workers' compensation insurance? Yes ☐ No ☐		Are you receiving disability insurance? Yes ☐ No ☐	
From which company:		How Many days so far:	
Is there anything else you can think of that we should know?			

Thank you for taking your time to fill out this form. Even though it was time-consuming, it provides us with valuable information that we need to properly take care of your case. Please be assured that **we will keep this information strictly confidential** and will not release it to anyone outside The Law Offices of Dianne L. Sawaya, unless you tell us to or give us permission to as part of your case, or as may be required by law.