CLIENT INFORMATION SHEET

CLIENT INFORMATION

Today's Date:_____Date of Loss_____Statute:_____

Client Name:_____

Client Address:_____

_____

Phones: Home:_____Work:_____

Other Contact Name and Phone:_____

Soc. Sec. #:_____ Date of Birth:_____

Email address: _____

ACCIDENT INFORMATION

Accident Reporting Agency_____Case #_____

Location of Accident_____

Client Vehicle Year, Make, and Model _____
Total Repair Costs: _____
Photographs of Client Vehicle: _____ Y _____ N
Photographs; Where Taken:_____

Defendant Vehicle Year, Make, and Model _____
Total Repair Costs: _____
Photographs of Defendant Vehicle: _____ Y _____ N
Photographs; Where Taken:_____

Description of Accident: (Enter into SP)_____

_____

_____

WITNESSES NAMES, ADDRESSES, PHONE #: _____

_____

_____

_____

_____

CLIENT INSURANCE

Insured Name_____

Name of Insurance _____

Address_____

Adjuster_____Phone_____

Claim #_____Policy #_____

PIP Limits_____
Underinsured Limits_____
Uninsured Limits: Limits_____

DEFENDANT AUTO INSURANCE

Driver Name_____Age_____

Insured Name_____

Name of Insurance _____

Address_____

Adjuster_____Phone_____

Claim #_____Policy #_____

BI Limits_____ Umbrella Policy YES NO

WAGE LOSS: (Insert in OSP)

Job Title_____

Description Of Duties_____ _____

Lost Work Units_____Pay per Unit_____

Total Lost Wages_____Future Lost Incm_____

Explanation_____

_____

_____

_____

_____

LIFESTYLE IMPACT (Input in OSP)_____

_____

_____

_____

_____

_____

_____

PHYSICAL CONDITION (Input in OSP)_____

_____

_____

_____

_____

_____

PRE-EXISTING MEDICAL HISTORY:

GENERAL HEALTH_____

_____

_____

HOSPITALIZATIONS_____

_____

PRIOR ACCIDENTS, AUTO/OTHER_____

_____

_____

_____

PRIOR INJURIES_____

ENTER MEDICAL PROVIDERS ON REPORT FORMS (Insert Names in OSP)