SUNSPOT
MEDIA & BUSINESS LAW

# Motor Vehicle Accident Intake

*Personal injury – automobile, motorcycle, truck, pedestrian, or bicycle collision*

## CLIENT / CONTACT INFORMATION

First Name | Middle Name | Last Name

Preferred Name | Date of Birth | Social Security No.

Gender | Marital Status | Driver's License No. | State

Street Address | City

State | Zip Code | County

Mobile Phone | Home Phone | Work Phone

Email Address | Preferred Contact Method

Employer | Occupation

Emergency Contact Name | Emergency Contact Phone

How Did You Hear About Us | Language / Interpreter Needed

## ACCIDENT DETAILS

Date of Accident | Time of Accident | Your Age at Accident

Location / Street | City

County | State | Nearest Cross Street

Weather Conditions

- ☐ Clear
- ☐ Rain
- ☐ Snow/Ice
- ☐ Fog
- ☐ Windy
- ☐ Dark
- ☐ Other

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Road Conditions

- ☐ Dry
- ☐ Wet
- ☐ Icy
- ☐ Construction
- ☐ Debris
- ☐ Other

You were the

- ☐ Driver
- ☐ Passenger
- ☐ Pedestrian
- ☐ Cyclist
- ☐ Motorcyclist

Describe in your own words how the accident happened

## POLICE & CITATIONS

Were police called to the scene? ☐ Yes ☐ No

Responding Agency

Report / Case Number

Were you cited or ticketed? ☐ Yes ☐ No

Was the other driver cited or ticketed? ☐ Yes ☐ No

Citation details (who / what for)

## YOUR VEHICLE

Year | Make | Model | Color

License Plate | Registered Owner

Vehicle Currently Located At

Est. Damage / Repairs

Were you wearing a seatbelt? ☐ Yes ☐ No

Did airbags deploy? ☐ Yes ☐ No

Was the vehicle drivable after the accident? ☐ Yes ☐ No

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Passengers in your vehicle (names / ages / injuries)

## OTHER DRIVER / AT-FAULT PARTY

Driver Name

Phone

Address

Driver's License No.

Vehicle Year / Make / Model

License Plate

Insurance Carrier

Policy Number

Did the other driver admit fault? ☐ Yes ☐ No

Was there more than one other vehicle involved? ☐ Yes ☐ No

## INSURANCE COVERAGE

Your Auto Insurance Carrier

Policy Number

Claim Number

Adjuster Name

Adjuster Phone

Liability Limits

UM / UIM Coverage

MedPay / PIP Coverage

Health Insurance Carrier

Policy / Member No.

Government coverage (check all that apply)

☐ Medicare ☐ Medicaid ☐ VA ☐ TRICARE ☐ None

Have you given a recorded statement to any insurer? ☐ Yes ☐ No

## INJURIES

Describe your injuries and the body parts affected

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Were you transported by ambulance? ☐ Yes ☐ No

Did you go to an emergency room? ☐ Yes ☐ No

Are you currently receiving treatment? ☐ Yes ☐ No

Did you have prior injuries to the same body parts? ☐ Yes ☐ No

Prior injuries / pre-existing conditions (if any)

## MEDICAL PROVIDERS & BILLS

*List every provider seen for this accident (hospital, ER, primary care, chiropractor, PT, imaging, specialists).*

Providers – name, city, dates of treatment

Estimated Total Medical Bills to Date

Outstanding Balance

Are there any medical liens against your case? ☐ Yes ☐ No

## LOST WAGES & EMPLOYMENT IMPACT

Have you missed work because of this accident? ☐ Yes ☐ No

Dates / Days Missed

Pay Rate

Estimated Lost Income

Are you self-employed? ☐ Yes ☐ No

Employer Contact for Wage Verification

Phone

## WITNESSES, EVIDENCE & PRIOR CLAIMS

Witnesses – names and phone numbers

Do you have photos or video of the scene, vehicles, or injuries? ☐ Yes ☐ No

Have you had prior accidents or personal injury claims? ☐ Yes ☐ No

Are you currently represented by another attorney for this matter? ☐ Yes ☐ No

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Additional information you want us to know

## ACKNOWLEDGMENT

*Completing this form does not create an attorney-client relationship. It is used to evaluate a potential matter and is kept confidential.*

Client / Representative Signature

Date

Staff Member Completing Intake

Date