

**CLIENT INFORMATION SHEET**

*The information you give us on this form is very important. It will help us investigate your accident and determine how to best proceed with your case. If you don't have all the information we ask for in this form, please let us know so we can help you get it. All of your answers will be kept strictly confidential.*

Today's date: \_\_\_\_\_

How were you referred to **The Law Offices of Dianne L. Sawaya, LLC?**

\_\_\_\_\_

**PERSONAL INFORMATION**

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

Telephone no.: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you: Right-handed \_\_\_\_\_ Left-handed: \_\_\_\_\_

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's phone no.: \_\_\_\_\_

Dependents and ages: \_\_\_\_\_

\_\_\_\_\_

Your driver's license: No. \_\_\_\_\_ Exp. date: \_\_\_\_\_

**\*\*\*\*IMPORTANT INFORMATION\*\*\*\***

Please list the name of a relative or friend who does not live with you:  
(for contact in an emergency and we can't reach you)

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

**INFORMATION ABOUT THE ACCIDENT**

When did the accident happen? Date: \_\_\_\_\_ Time: \_\_\_\_\_

Where did the accident happen? \_\_\_\_\_

Please briefly describe what caused the accident and how it happened:

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Were you injured when you fell? Yes \_\_\_ No \_\_\_

Please describe any bruises, cuts or other visible injuries that were caused by the accident (for example, bruises or cuts):

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Did you hit your head when you fell? Yes \_\_\_ No \_\_\_

Did you lose consciousness? Yes \_\_\_ No \_\_\_ For how long? \_\_\_\_\_

If you don't think you lost consciousness, is there anything about the incident you don't recall (such as time of the accident, people nearby, sounds)? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

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What other injuries did you suffer? \_\_\_\_\_

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Please list any medical conditions or ongoing symptoms that you think might have been caused by this accident:

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Was an ambulance called to the scene? Yes \_\_\_ No \_\_\_ Name: \_\_\_\_\_

Were you transported to the hospital? Yes \_\_\_ No \_\_\_

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

<b>FACILITIES</b>	<b>FULL NAME</b>	<b>PHONE NUMBER/ADDRESS</b>
Emergency department:		
Hospital		
Imaging center (X-rays, MRI etc.)		
Walk-in clinic:		
Doctor:		
Chiropractor:		
Physical therapist:		
Other:		

**OTHER IMPORTANT INFORMATION**

If you slipped on something, what did you slip on? \_\_\_\_\_

If you fell because of a substance or a dangerous condition, is there anyone who might know something about the substance or condition as it existed before you fell? Yes \_\_\_ No \_\_\_

If so, please list that person or persons:

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Were police notified? Yes \_\_\_ No \_\_\_ Did the police investigate the accident? Yes \_\_\_ No \_\_\_

Which police department/city? \_\_\_\_\_

Did anyone take photographs at the accident scene? Yes \_\_\_ No \_\_\_

Their name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Did you make any statements to anyone at the scene? Yes \_\_\_ No \_\_\_

To whom: \_\_\_\_\_

What did you say? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did anyone make any statements to you at the scene? Yes \_\_\_ No \_\_\_

Who made the statements? \_\_\_\_\_

What did they say? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did you file a report with management? Yes \_\_\_ No \_\_\_ Did you get a copy? Yes \_\_\_ No \_\_\_

Did you receive any insurance info (i.e. Where to send medical bills to?) Yes \_\_\_ No \_\_\_

Name of Insurance: \_\_\_\_\_ Claim number: \_\_\_\_\_

Adjuster name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have health insurance? Yes \_\_\_ No \_\_\_

Name of plan: \_\_\_\_\_

Insurer contact: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Group/policy no.: \_\_\_\_\_ Member no.: \_\_\_\_\_

Does Medicare or Medicaid pay any of your medical bills? Yes \_\_\_ No \_\_\_

If yes, what is your Medicare/Medicaid no.: \_\_\_\_\_

### **INFORMATION ON WITNESSES**

Were there any witnesses to the accident? Yes \_\_\_ No \_\_\_

Please list any witnesses who saw what happened:

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

**INFORMATION ABOUT YOUR WORK**

Were you on the job at the time of the accident? Yes \_\_\_ No \_\_\_

Has this incident affected your ability to do your job? Yes \_\_\_ No \_\_\_

If yes, please complete the following information:

Employer's name: \_\_\_\_\_

Employer's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Income at the time of the accident: \$\_\_\_\_\_ per \_\_\_\_\_

Any other income (commissions, bonuses, second job etc.): \$\_\_\_\_\_

Income now: \$\_\_\_\_\_ per \_\_\_\_\_

As a result of this accident, have you missed any time from work? Yes \_\_\_ No \_\_\_

Are you working now? Yes \_\_\_ No \_\_\_

Are you receiving worker's compensation insurance? Yes \_\_\_ No \_\_\_

Are you receiving disability insurance? Yes \_\_\_ No \_\_\_

For how many days so far: \_\_\_\_\_

Name of the doctor who told you not to work: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

*Thank you for taking your time to fill out this form. 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.*