PRYOR LAW

This accident fact sheet was created by Pryor Law, Injury Attorneys, to help gather information from our potential clients regarding accidents they were involved in. Feel free to leave sections that do not apply blank and/or attach additional documents as needed.

ACCIDENT FACT SHEET

DATE: ___/___/____

PLAINTIFF-CLAIMANT INFORMATION:

NAME: _____

AGE: _____

D.O.B: ___/___/___

SS #____/___/____

SPOUSE/GUARDIAN: _____

HOME ADDRESS: _____

TELEPHONE NO: _____

E-MAIL: _____

CASE INFO:

PREVIOUS CLIENT? YES ◯ NO ◯

RECOMMENDED BY: _____

RELATION TO CLIENT: _____

EMPLOYER: _____

BUSINESS ADDRESS: _____

OCCUPATION: _____ TELEPHONE NO: _____

TIME LOST: _____ HOW LONG: _____ EARNINGS: $_____

(If a Student)

SCHOOL: _____

SCHOOL ADDRESS: _____

TIME MISSED FROM SCHOOL: _____

IS THIS A DISABILITY CLAIM? YES◯ NO◯ [File within 30 Days]

MEDICARE/MEDICAID RECIPIENT: YES◯ NO◯ (If yes, need copy of card)

ACCIDENT:

TYPE: _____

DATE: _____ APPROX. HOUR: _____ DAY OF WEEK: _____

LOCATION: _____

_____

POLICE REPORT: Yes◯ No◯

POLICE OFFICER(S):

_____ PCT. _____ SHIELD #_____

_____ PCT. _____ SHIELD #_____

SUMMONS/ARREST AND DISPOSITIONS: _____

_____

WITNESSES, ETC.:

_____

_____

_____

MANNER OF ACCIDENT:

_____

_____

_____

_____

STATEMENTS MADE AT SCENE OF ACCIDENT:

_____

_____

VECHICLE PLAINTIFF WAS TRAVELING IN:

VEHICLE OWNED BY: _____

INSURANCE POLICY HOLDER: _____

INSURANCE POLICY NUMBER: _____

Please attach insurance policy declaration page and any applicable umbrella coverage policy information.

PHYSICAL CONDITIONS:

WEATHER: _____

ROAD: _____

TYPE & LOCATION OF TRAFFIC CONTROL: _____

NUMBER & DIRECTION OF TRAFFIC LANE(S): _____

ONE-WAY OR TWO-WAY STREET: _____

PARKED VEHICLES: _____

OTHER PHYSICAL CONDITIONS: _____

_____

VEHICLE ACTIONS:

SIGNALS: _____ SPEED: _____ SKID MARKS: _____

DEFECTIVE EQUIPMENT: _____ VIOLATIONS: _____

OTHER PERSONS INJURED:

_____

_____

OTHER INFO: _____

_____

DEFENDANT/LIABLE PARTY INFO:

NAME: _____

RESIDENCE/BUSINESS ADDRESS: _____

TELEPHONE NO: _____ OCCUPATION: _____

INSURER: _____ CLAIM NO: _____

ADDRESS: _____

ADJUSTER: _____ TEL.NO: _____

DAYS IN OFFICE: _____ ATTORNEYS: _____

MEDICAL INFO:

HOSPITAL: _____

HOW TAKEN: _____

ADDRESS: _____

TEL.NO: _____ ADMITTED: ___/___/____ DISCHARGED: ___/___/____

HOSPITAL DOCTORS: _____

EXAMINATION-TREATMENT: _____

_____

AMOUNT OF BILL: $_____ PAID? _____

DATE: ___/___/___ BY WHOM: _____

FOLLOW UP TREATMENT:

DOCTOR: _____ AMOUNT OF BILL: $ _____

ADDRESS: _____

DATE: ___/___/____ TELEPHONE NUMBER: _____

DOCTOR: _____ AMOUNT OF BILL: $ _____

ADDRESS: _____

DATE: ___/___/____ TELEPHONE NUMBER: _____

EXAMINATIONS; X-RAYs; MRIs; TREATMENTs; DURATION: _____

_____

CONFINED TO BED/HOME: _____ MEDICINES/SUPPLIES: $ _____

INJURIES and PERMANENCY: _____

_____

PRIOR INJURIES: _____

_____

_____

HOUSEHOLD HELP & MISC. EXP: _____

_____

_____

NOTES/COMMENTS:

_____

_____

_____