STAHL & HIDIR, P.C.

Today's Date

_____ **PERSONAL INJURY CLIENT INFORMATION**

PLEASE PRINT CLEARLY

YOUR INFORMATION	**SPOUSE INFORMATION**
FULL NAME _____	FULL NAME _____
ADDRESS _____	ADDRESS _____
CITY_____, STATE_____	CITY_____, STATE_____
ZIP CODE_____ COUNTY_____	ZIP CODE_____ COUNTY_____
How long at this residence?_____	How long at this residence?_____
CONTACT NUMBERS / EMAIL	**CONTACT NUMBERS / EMAIL**
(H)_____	(H)_____
(W)_____	(W)_____
(C)_____	(C)_____
EMAIL_____	EMAIL_____
SSN_____	SSN_____
DATE OF BIRTH _____	DATE OF BIRTH _____
EMPLOYER_____	EMPLOYER_____
POSITION_____ HOW LONG?_____	POSITION_____HOW LONG_____

EMERGENCY/ADDITIONAL CONTACTS

NAME_____ RELATION_____ NUMBER_____

NAME_____ RELATION_____ NUMBER_____

ACCIDENT INFORMATION

DATE _____

LOCATION_____

CITY_____, STATE_____

ZIP CODE_____ COUNTY_____

WHO WAS CITED OR DETERMINED TO BE AT FAULT?
_____

BRIEF DISCRIPTION OF ACCIDENT:
_____

_____

_____

_____

_____

_____

WHICH LAW ENFORCEMENT AGENCY RESPONDED TO THE ACCIDENT?
_____

DESCRIBE INJURY

_____

PLEASE BRING COPY OF ACCIDENT REPORT WITH YOU FOR YOUR APPOINTMENT

YOUR AUTO INSURANCE INFORMATION

PROVIDER_____

MEMBER/POLICY NUMBER_____

PHONE_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

DO YOU HAVE UNINSURED MOTORIST COVERAGE? (select one) Yes No

DO YOU HAVE A MEDICAL PAYMENT PROVISION ON YOUR POLICY? (select one) Yes No

HAVE YOU REPORTED THIS ACCIDENT TO YOUR PROVIDER? (select one) Yes No

If yes, please list claim number _____

YOUR HEALTH INSURANCE INFORMATION

PROVIDER_____

MEMBER/POLICY NUMBER_____

PHONE_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

HAVE YOU OR TREATING FACILITY SUBMITTED ANY CLAIMS RELATED TO THIS ACCIDENT TO YOUR PROVIDER? (select one) Yes No

TREATMENT RELATED TO ACCIDENT
(begin with ambulance transportation, if any, then ER, doctors, chiropractic, rehabilitation, etc.)

PROVIDER 1_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

PROVIDER 2_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

PROVIDER 3_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

Please bring any and all bills you have received from providers to your appointment

PROVIDER 4_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

PROVIDER 5_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

PROVIDER 6_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

PROVIDER 7_____

DATE(S) OF TREATMENT_____

ADDRESS _____

CITY_____, STATE_____

ZIP CODE_____

HOW DID YOU HEAR ABOUT OUR FIRM?

_____ Referral from _____
_____ I'm a previous client
_____ AT&T Printed Yellow Pages (Phone book)
_____ Online Research

_____ Google
_____ AT&T Online Yellow Pages
_____ FindLaw
_____ Other

ATTORNEY'S NOTES