

Referred By: \_\_\_\_\_  
Appointment set: \_\_\_\_\_

Date: \_\_\_\_\_  
Handler Initials: \_\_\_\_\_

## **MOTOR VEHICLE ACCIDENT INTAKE**

**DATE OF ACCIDENT:** \_\_\_\_\_

<b>Client No. 1:</b>	<b>Client No. 2:</b>
Address:	Address:
Phone:	Phone:
DOB:	DOB:
<input type="checkbox"/> Driver <input type="checkbox"/> Owner <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other:	<input type="checkbox"/> Driver <input type="checkbox"/> Owner <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other:
Injuries:	Injuries:
<input type="checkbox"/> Liability <input type="checkbox"/> UM <input type="checkbox"/> PIP <input type="checkbox"/> Collision	(Answer If different from Client No. 1)
Notified Ins. Co.? <input type="checkbox"/> Yes <input type="checkbox"/> No	(Answer If different from Client No. 1)
Statement given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: To whom? Recorded/Written?	Statement given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: To whom? Recorded/Written?
Health Insurance?	Health Insurance:

**FILL IN THE FOLLOWING, OR ATTACH POLICE REPORT:**

Day of Week of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_  am  pm  During sunrise  During Sunset/Twilight

County: \_\_\_\_\_ State: \_\_\_\_\_

Speed limit: \_\_\_\_\_ Client speed: \_\_\_\_\_ Defendant speed: \_\_\_\_\_

Weather conditions: \_\_\_\_\_

Road condition: \_\_\_\_\_

Type of road:  Asphalt  Concrete  Brick/cobblestone  Gravel  Dirt  Other \_\_\_\_\_

Location of Accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Police called?  Yes  No

Ticket(s) issued?  Yes  No

Police report?  Yes  No

To: \_\_\_\_\_ For: \_\_\_\_\_

To: \_\_\_\_\_ For: \_\_\_\_\_

Property damage *other than motor vehicles*?

Yes  No

Disposition of ticket(s) if any: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(attach extra sheet if necessary)

**BRIEF DESCRIPTION OF ACCIDENT:**

Who hit whom? \_\_\_\_\_

\_\_\_\_\_

How many cars involved? \_\_\_\_\_

Who was at fault? \_\_\_\_\_

How much is each vehicle damaged? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was an ambulance called?  Yes  No

Have you been to the doctor yet?  Yes  No If so, what is the diagnosis? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Losing time from work?  Yes  No Dates of lost time: \_\_\_\_\_

Salary: \_\_\_\_\_

*NOTES:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_