

**PERSONAL INJURY INFORMATION SHEET**

DATE : \_\_\_\_\_ REF BY: \_\_\_\_\_ O/C \_\_\_\_\_ TV \_\_\_\_\_

D/A: \_\_\_\_\_ TYPE: \_\_\_\_\_ TIME: \_\_\_\_\_

NAME: \_\_\_\_\_

SPOUSE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_

HOME/CELL # \_\_\_\_\_ E-MAIL: \_\_\_\_\_

S.S. NO.: \_\_\_\_\_ D/O/B: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_

PRIOR ACCIDENTS: \_\_\_\_\_

PRIOR ATTORNEY: \_\_\_\_\_ PRIOR CLINIC: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP \_\_\_\_\_

**ACCIDENT INFORMATION**

LOCATION OF ACCIDENT: \_\_\_\_\_

POLICE DEPT: \_\_\_\_\_ **Miami-Dade** **City of Miami** **FHP** SEATBELTS: \_\_\_\_\_

HOW DID ACCIDENT HAPPEN? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

INJURIES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RESCUE: \_\_\_\_\_ YES NO TRANSPORTED NOT TRANSPORTED

HOSPITAL: \_\_\_\_\_

TREATING DOCTOR(S)

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TEL: \_\_\_\_\_

TEL: \_\_\_\_\_

**VEHICLE INFORMATION**

TYPE OF CAR: \_\_\_\_\_ MODEL: \_\_\_\_\_ COLOR: \_\_\_\_\_

LOCATION OF CAR: \_\_\_\_\_

PICTURES OF CAR: \_\_\_\_\_

**WITNESS INFORMATION**

WITNESS: \_\_\_\_\_

TEL. NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

WITNESS: \_\_\_\_\_

TEL. NO.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

1ST PARTY INS: \_\_\_\_\_

ADJUSTER: \_\_\_\_\_

TEL.: \_\_\_\_\_

POLICY NO.: \_\_\_\_\_ CLAIM NO.: \_\_\_\_\_

COVERAGE: \_\_\_\_\_ U.M. \_\_\_\_\_

3RD PARTY INS: \_\_\_\_\_

PD ADJUSTER: \_\_\_\_\_

TEL.: \_\_\_\_\_

BI ADJUSTER: \_\_\_\_\_

TEL: \_\_\_\_\_

CLAIM NO.: \_\_\_\_\_ POLICY:# \_\_\_\_\_

COVERAGE: \_\_\_\_\_

HEALTH INSURANCE: \_\_\_\_\_ POLICY NO.: \_\_\_\_\_

LOSS WAGES: \_\_\_\_\_

PROPERTY DAMAGE AMOUNT PAID: \$ \_\_\_\_\_

PAID BY: \_\_\_\_\_