

Law Offices of Michael J. Gopin

Today's Date: _____, 200__

ABOUT YOU

Full Name _____

Home Phone (____) _____ Cell Phone (____) _____

SS# _____ - _____ - _____ Date of Birth _____ Age _____

Home Street Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Email Address _____

May we register you for our free e-newsletter? _____

Employer _____ Occupation _____

Work Phone (____) _____

Marital Status _____ # of Children _____

If emergency call _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

ABOUT YOUR SPOUSE

Spouse's Full Name _____ Date of Birth _____

Age _____ SS# _____ - _____ - _____

Work Phone (____) _____ Cell Phone (____) _____

Employer _____ Occupation _____

ABOUT YOUR ACCIDENT

Date of accident _____ Approx. time of accident ____:____ a.m. ____:____
p.m.

Case #, if available _____ Location of accident _____

Injuries sustained _____

Did your injury occur while "on the job"? Yes ____ No ____

How were you referred to this office? _____

Are your injuries related to an traffic accident? Yes _____ No _____

How many vehicles were involved in the accident? _____

How many passengers were in your vehicle? _____

Were you a driver or passenger? _____

Did any airbags deploy? Yes _____ No _____ If so, which ones? _____

Were you cited? _____ If so, for what? _____

Have you missed any work because of the accident? Yes _____ No _____

Have you talked to anyone from any ins company about this accident? Yes _____ No _____

Have you given a recorded statement to anyone regarding this accident? Yes ___ No

ABOUT YOUR VEHICLE

Year _____ Make _____ Model _____

Owner of Vehicle? Self ___ If other, who? _____ Relation _____

Was your vehicle towed from the scene of the accident? Yes _____ No _____

Where is your vehicle located? _____ Is your vehicle drivable? Yes ___ No ___

Is there a lienholder? Yes _____ No _____ If yes, who is the lienholder? _____

ABOUT YOUR AUTO INSURANCE

Insurance Company _____

Address _____

Contact _____ Phone (_____) _____

Named Insured: _____ Excluded Drivers (if any) _____

Policy/Claim # _____

Coverage ("x" if applicable):

Liability _____ Collision _____ Comprehensive _____ UIM _____ PIP _____
Med Pay _____

DEFENDANT'S AUTO INSURANCE

Insurance Company _____

Address _____

Contact _____ Phone (____) _____

Named Insured: _____ Owner of Vehicle: _____

Policy/Claim # _____

ABOUT YOUR HEALTH INSURANCE

Do you have health insurance? Yes _____ No _____

If yes, name of company _____

Do you have Medicaid or Medicare? Yes _____ No _____

If yes, give case # _____

ABOUT YOUR MEDICAL TREATMENT

Were you taken from the scene of the accident by Ambulance? Yes _____ No _____

Hospital: _____

X-Rays Taken?: _____

Treating Physicians: _____

Referred to: _____

Any prior injuries/accidents? No _____ Yes _____ When _____

DESCRIPTION OF ACCIDENT

—

OTHER OCCUPANTS

FULL NAME: _____

DOB: _____ AGE: _____ SS#: _____

Were you taken from the scene of the accident by Ambulance? Yes ____ No ____

Hospital: _____

X-Rays Taken? _____

Treating Physicians: _____

Referred to: _____

Any prior injuries/accidents? No ____ Yes ____ When _____

FULL NAME: _____

DOB: _____ AGE: _____ SS#: _____

Were you taken from the scene of the accident by Ambulance? Yes ____ No ____

Hospital: _____

X-rays Taken? _____

Treating Physicians: _____

Referred to: _____

Any prior injuries/accidents? No ____ Yes ____ When _____

FULL NAME: _____

DOB: _____ AGE: _____ SS#: _____

Were you taken from the scene of the accident by Ambulance? Yes ____ No ____

Hospital: _____

X-Rays Taken? _____

Treating
Physicians: _____

Referred to: _____

Any prior injuries/accidents? No ____ Yes ____ When _____