COWART LAW OFFICES

TIM COWART, ATTORNEY AT LAW

1003 BERRY STREET
LLANO, TX 78643
TEL: (325) 247-5486

COWARTLAW@GMAIL.COM

119 AVE G, STE. 101
MARBLE FALLS, TX 78654
TEL: (830) 798-1063

FAX: (866) 418-4160

INITIAL INTAKE FORM

PERSONAL INJURY INCIDENT INFORMATION SHEET - AUTO

Date_____

Client Name: _____Driver or Passenger? please circle)

Spouse's full name, if married: _____Driver or Passenger? please circle)

_____

Address City State/Zip Code

Home phone #_____ Work #_____Cell #_____

Preferred E-Mail _____Date of Birth _____

Social Security #_____Driver's License _____

Emergency Contact: Name:_____Address: _____

Home #_____Work#_____Cell#_____Email: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father: _____ Telephone:_____

Mother: _____ Telephone: _____

ACCIDENT INFORMATION

Date of Incident:_____Time of Incident:_____AM or PM (circle one)

City of Incident:_____County of Incident:_____

WERE THE POLICE CALLED TO THE SCENE?	Yes	No
WAS AN ACCIDENT OR INCIDENT REPORT FILED?	Yes	No
If the Police DID NOT file an Accident Report, did you file a Blue Form?	Yes	No

If yes, please state the accident or incident report number:_____

Did you have a passenger in car accident?	Yes	No

Please give passenger's full name: _____

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Did you go to the hospital? Yes_____No _____ _____
Name of hospital

Transported by ambulance? Yes_____No _____ _____
Name of ambulance service

Did they take x-rays? Yes_____No_____

ARE YOU STILL SEEING A DOCTOR NOW? Yes NO (List all Dr.'s name/address/number)

Do you anticipate any loss of earnings, due to accident related injuries? Yes_____No _____

UNDERSTANDNG OF HOW THE INCIDENT OCCURRED:

_____

_____

_____

_____

_____

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

NAME_____Contact Number: _____

_____
Address City State/Zip Code

Date of birth: _____ Social Security #:_____Driver's License:_____

INJURIES: _____

Did above go to the hospital? Yes_____No _____ _____
Name of hospital

Transported by ambulance? Yes_____No _____ _____
Name of ambulance service

Did they take x-rays? Yes_____No_____

IS ABOVE SEEING A DOCTOR NOW? Yes NO List all Dr.'s name/address/number)

_____

_____

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INITIAL INTAKE FORM

PASSENGERS/COMPANIONS (if applicable): continued

NAME_____Contact Number: _____

_____

Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

Driver's License: _____Spouse's Name, if Married: _____

INJURIES: _____

Did above go to the hospital? Yes_____No _____ _____
Name of hospital

Transported by ambulance? Yes_____No _____ _____
Name of ambulance service

Did they take x-rays? Yes_____No_____

IS ABOVE SEEING A DOCTOR NOW? Yes _____

_____

_____

Do you anticipate any loss of earnings, due to accident related injuries? Yes_____No _____

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INITIAL INTAKE FORM

IF APPLICABLE: PROPERTY DAMAGE
(Damage to your vehicle)

DO YOU NEED HELP IN RESOLVING THE DAMAGE TO YOUR VEHICLE? Yes_____No _____
(There is NO fee for this service, unless the payment of the property damage in your case is contested)

IS YOUR VEHICLE DRIVABLE? Yes_____No _____Estimated Damage: $_____

WHERE IS YOUR VEHICLE LOCATED? _____

Your vehicle's year_____Make_____Model:_____Color_____License Plate:_____

Do your have clear title to your vehicle? Yes_____No_____

If not, who is the owner of your vehicle? _____

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you supply us with pictures of your vehicle? Yes_____No_____, **IF NOT**,

Is your vehicle available for us to take pictures? Yes_____No _____

IF APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto insurance carrier: _____ Policy Number:_____

Name of Policy Holder: _____Agent _____

Telephone Number: _____ Claim Number (if known): _____

Type of Coverage:_____PIP Limits: $ _____

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INITIAL INTAKE FORM

DEFENDANT INFORMATION: IF APPLICABLE
AUTOMOBILE INSURANCE

Driver's Name:_____ Telephone Number: _____

Address: _____

_____ _____
Driver's Date of Birth, if known Driver's license number, if known

Name of InsuranceCarrier: _____

Agent/Adjuster: _____

Telephone Number:_____Fax Number: _____

Policy Number (if known):_____Claim Number: _____

DESCRIPTION OF DEFENDANT'S (other driver) VEHICLE:

Year, Make and Model:_____ Plate Number: _____

Owner's Name, if different from driver: _____

Were there passengers in the other driver's vehicle? Yes_____ No _____
If yes, how many? _____

Were there independent witnesses (individuals who were **not involved** in the accident who saw what happened?)
Yes_____ No ____

Please list the following with respect to any independent witnesses:

Name: _____ Phone Number: _____

Address:_____

Name:_____ Phone Number:_____

Address:_____

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INITIAL INTAKE FORM

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail: _____

_____

Did you go to the hospital? Yes _____ No_____ _____
Name of Hospital

Did you go by ambulance? Yes _____ No_____ _____
Name of Ambulance Service

Did they take x-rays? Yes_____No _____

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes_____ No _____

If yes, please list all Doctors: name, address and telephone number

_____

_____

B&G REFERRED TO: _____
(for office use only)

LOSS OF EARNINGS

IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING:

Employer: _____

Your position or title: _____

Rate of Pay: $_____per hour or $_____yearly salary

How many hours do you normally work per week? _____

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of InsuranceCarrier: _____

PPO, HMO, Medicaid, other (please circle one)

Name of Policy Holder: _____

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INITIAL INTAKE FORM

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes_____No _____

If yes, please state, to whom given and when: _____

_____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS
(**Please DO NOT leave blank, if none, so state)**

DATE	NATURE OF ACCIDENT OR INCIDENT (auto, work related, slip & fall, medical negligence?)	INJURIES

How were you referred to us? (Circle one) I am a previous client Office sign Web Site

Phonebook: name of book_____Other _____
(please describe how you came to Bailey & Galyen today)

Name of person who referred you: _____
their address: _____
their telephone: _____

DO YOU CURRENTLY HAVE A WILL? Yes_____ No _____
HAVE YOU BEEN DENIED SOCIAL SECURITY BENEFITS? Yes_____No_____
HAVE YOU BEEN DENIED VETERANS BENEFITS? Yes_____No_____
DO YOU HAVE NEED LEGAL ASSISTANCE IN AN IMMIGRATION MATTER? Yes____No_____

FOR OFFICE USE ONLY

INTERVIEWER: _____

OFFICE LOCATION: _____

HOME VISIT/DOCTOR'S OFFICE: _____

DATE OF VISIT: _____

DID THE CLIENT RETAIN Yes_____No _____

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INITIAL INTAKE FORM

IF APPLICABLE: WRONGFUL DEATH INFORMATION SHEET

Client(s) relationship to Decedent: _____

Decedent's Name: _____

_____
Address City State/Zip Code

Decedent's:
Date of Birth _____ Social Security #_____Driver's License # _____

Decedent's Employer: _____

_____
Address City State/Zip Code

Job Title/Description: _____

Salary wage rate:_____Length of Time @ employment _____

Education: High School: Yes_____No _____ Graduated: Yes _____ No_____; College: Yes__ No _____ Degree:

Yes _____ No_____Post Graduate Yes _____ No _____ Degree: Yes _____ No _____

Other (Please List): _____

WAS DECEDENT MARRIED:_____YES _____NO

NAME OF SPOUSE: _____

CHILDREN: YES_____NO _____

NAME:_____ AGE: _____

ADDRESS:_____ PHONE #: _____

NAME:_____ AGE: _____

ADDRESS:_____ PHONE #: _____

NAME:_____ AGE: _____

ADDRESS:_____ PHONE #: _____

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INITIAL INTAKE FORM

IF APPLICABLE: PRODUCT LIABILITY

PRODUCT COMPLAINED OF: _____

FROM WHAT ENTITY WAS THE PRODUCT PURCHASED: _____

PLACE OF PURCHASE: _____

DATE THE PRODUCT WAS PURCHASED: _____

WHO PURCHASED THE PRODUCT: NAME: _____

ADDRESS: _____ PHONE # _____

ARE THERE PURCHASE/TRANSACTION DOCUMENTS: YES_____ NO _____

IF YES, CAN YOU SUPPLY: YES_____ NO _____

PRODUCT SPECIFIC INFORMATION:

MANUFACTURER: _____

MODEL NUMBER: _____

SERIAL NUMBER: _____

ARE THERE INSTRUCTION SHEETS, LIMITED WARRANTIES AND/OR OWNER MANUALS FOR THE PRODUCT COMPLAINED OF: YES_____ NO _____

CAN YOU SUPPLY US WITH THIS INFORMATION: YES _____ NO _____