Client Intake Form
Dog Bite

Today's Date: ____

First Name: ________________ Middle Name ____________ Last Name: ________________

Address: ____ City: __________ State: _______

Home Phone: _________________Cell Phone: _______________Work Phone:______________

Email Address: ____

Date of Birth: ______________________ SSN:___________________________________

Married ___ Single ___ Divorced ___ Widowed ___ Minor ___

Spouse's Name: ____

Spouse's Date of Birth: ________________ Spouse's SSN:___________________________

ACCIDENT DETAILS

Date of Accident: ______________________________ Time of Accident: ________________

What was the street location of the accident? ____

City: ____ State: _________________________

Did police arrive at the location of the accident? Yes _____ No _____

What police department? ____

Is there a police report number (can be found on accident exchange form)? ______________________

If yes, who? ____

Did this dog bite occur on private property? Yes _____ No _____

If yes, how would you describe the property where this accident occurred? (single-dwelling home, multi-dwelling home/condominium, apartment, retail/commercial property?) ___________________________

____

____

Did this dog bite occur on a sidewalk or other public area? Yes _____ No _____

If yes, explain where: ____

Do you know the name of the homeowner/tenants/business owner on the property where this occurred?

Yes _____ No _____

If yes, please list all residents/occupants ____

____

Describe in detail how this accident happened: ____

____

____

____

____

Please draw a diagram of the accident scene:

Do you have any pictures of the location where this accident occurred? Yes _____ No _____

Do you know the name of the insurance carrier of the owners/tenants where this accident occurred?

Yes _____ No _____ If yes, please list the name(s) of the insurance company: ______________________

____

Did you report this accident to any insurance agent or company? Yes _____ No _____

Did you give a statement to any insurance company? Yes _____ No _____

If yes, when and what insurance company? ____

Please list any claim numbers you have been given by any insurance carrier for this accident __________

____

INJURIES AND TREATMENT

What injuries did you receive from this dog bite? ____

____

Did you go to the hospital due to your injuries? Yes _____ No _____

If yes, were you transported from the scene via ambulance? Yes _____ No _____

Provide the name of ambulance company: ____

Provide the name of the hospital: ____

How long did you stay at the hospital? ____

What kind of treatment did you receive from the hospital? ______________________________________

____

Did you have x-rays, MRI or other diagnostic tests? ____

Please list all other providers you have treated with or are currently treating with as a result of this accident (specialist, chiropractor, primary care physician, physical therapy, rehabilitation)?

Name: _______________________________________ Phone Number:___________________________

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Name: _______________________________________ Phone Number:___________________________

Name: _______________________________________ Phone Number:___________________________

What is the approximate amount of your medical bills? $_______________________________________

Do you have any scarring or disfigurement from this accident? Yes _____ No _____

If yes, did you take any photographs of your injuries or scarring/disfigurement? Yes _____ No _____

Has any medical professional indicated that you may need scar revision? Yes _____ No _____

If yes, list the medical professional and explain their recommendation: ____________________________

____

Did they give you an estimate cost for such future revision? _____________________________________

Do you have health insurance? Yes _____ No _____What carrier: _________________________________

Have you had any other injuries or medical treatment before this accident? Yes _____ No _____

Are the injuries/medical treatment within the past five years? Yes _____ No _____

If yes, please list year of previous accident, type of accident and type of injuries/medical treatment: _____

____

Were you taking any medication on the date of the accident? Yes _____ No _____

If yes, what medications? ____

Have you had any other injuries after this accident? Yes _____ No _____

If yes, please describe: ____

LOST INCOME OR WAGES

Did you miss work time as a result of this accident? Yes _____ No _____ How much time? ___________

Your employer/occupation: ____

Address: ____

Name of supervisor and telephone number: ____

ADDITIONAL INFORMATION

Have you or are you filing for bankruptcy? Yes: _____ No: _____

Are you paying child support? Yes: _____ No: _____

Do you currently or have you had another attorney in this matter? Yes _____ No _____

If yes, who is/was your other attorney? ____

Emergency contact information:

Please provide two names and phone numbers of close relatives that do not live with you:

Name: __________________________ Phone Number: _____________________ Relation: ____________

Name: __________________________ Phone Number: _____________________ Relation: ____________

How did you hear about us? ____

I____________________________ understand that this is a **free consultation** about my accident and that I am not represented until I speak with the attorney who agrees to accept my case and I sign a fee agreement. I understand that my case may or may not be accepted by the attorney.

Sign Name: _____________________________ Date: ____

Print Name: ____________________________ Date: ____