

CLIENT INFORMATION SHEET

FULL NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

OTHER PHONE: _____ E-MAIL _____

FACSIMILE: _____ WORK PHONE: _____

EMPLOYER: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

IF MARRIED, NAME OF SPOUSE: _____

NAME, ADDRESS, AND PHONE NUMBER OF YOUR NEAREST RELATIVE THAT DOES NOT LIVE WITH YOU:

HOW DID YOU CHOOSE OUR BUSINESS?: _____

REFERRAL (BY WHOM?): _____

DATE OF INCIDENT: _____

LOCATION OF INCIDENT: _____

PLEASE CHECK THE TYPE OF PROBLEM YOU WISH TO DISCUSS:

WORKER'S COMPENSATION: INSURANCE: ESTATE: BANKRUPTCY:

PERSONAL INJURY (AUTO ACCIDENT, ETC.): DEFECTIVE PRODUCT:

CONSUMER: OTHER:

HAVE YOU CONTACTED OR HAVE YOU BEEN UNDER CONTRACT WITH ANY OTHER ATTORNEY REGARDING THIS MATTER?:

NO YES PREVIOUSLY, BUT NOT AT THIS TIME

IF YOUR ANSWER WAS “YES” OR “PREVIOUSLY”, PLEASE EXPLAIN:

IF THIS INVOLVES AN AUTOMOBILE ACCIDENT, WAS THERE AN INVESTIGATION BY LAW ENFORCEMENT? YES NO

AGENCY: _____ ACCIDENT REPORT# _____

DO YOU HAVE A COPY OF THE REPORT? YES NO

WERE YOU A DRIVER OR A PASSENGER? _____

PLEASE LIST ANY ADDITIONAL OCCUPANTS IN YOUR VEHICLE:

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE: _____ PHONE: _____

You may use the back of this form to list additional passengers, if needed.

WAS AN AMBULANCE CALLED TO ASSIST YOU? YES NO

YOUR AUTOMOBILE INSURANCE COVERAGE:

COMPANY: _____ POLICY# _____

DO YOU HAVE UNDERINSURED/UNINSURED MOTORIST COVERAGES?

YES NO UNCERTAIN

DO YOU HAVE MEDICAL PAYMENTS THROUGH YOUR AUTO INSURANCE?

YES NO UNCERTAIN

DO YOU HAVE HEALTH INSURANCE COVERAGE? ___ YES ___ NO

IF "YES", PLEASE PROVIDE THE FOLLOWING:

NAME OF COMPANY: _____

POLICY #: _____ GROUP ID#: _____

INFORMATION REGARDING THE OTHER PARTY:

NAME: _____

ADDRESS: _____

AUTO INSURANCE: _____

ADJUSTER AND CLAIM#: _____

YOUR VEHICLE:

WAS YOUR VEHICLE TOWED? ___ YES ___ NO

IF "YES", WHERE WAS YOUR VEHICLE TAKEN?:

ARE THERE PHOTOGRAPHS OR VIDEO OF YOUR VEHICLE, THE SITE OF THE INCIDENT, OR THE

INCIDENT ITSELF? ___ YES ___ NO ___ UNCERTAIN

PLEASE DESCRIBE EXACTLY WHAT HAPPENED:

WORKER'S COMPENSATION: HAVE YOU EVER EXPERIENCED A WORK RELATED INJURY OR ILLNESS? ___ YES ___ NO

IF "YES", PLEASE EXPLAIN:

ADDITIONAL HISTORY AND INFORMATION: _____

PROVIDER LIST

Please list all of the healthcare providers that you have seen in regard to this incident. This includes ambulances, emergency rooms, hospitals, doctors, chiropractors, physical therapists, etc. If possible, please provide us with addresses, phone numbers, and dates of service. You may use the back of this form to list additional providers, if needed.

Primary Care Physician:

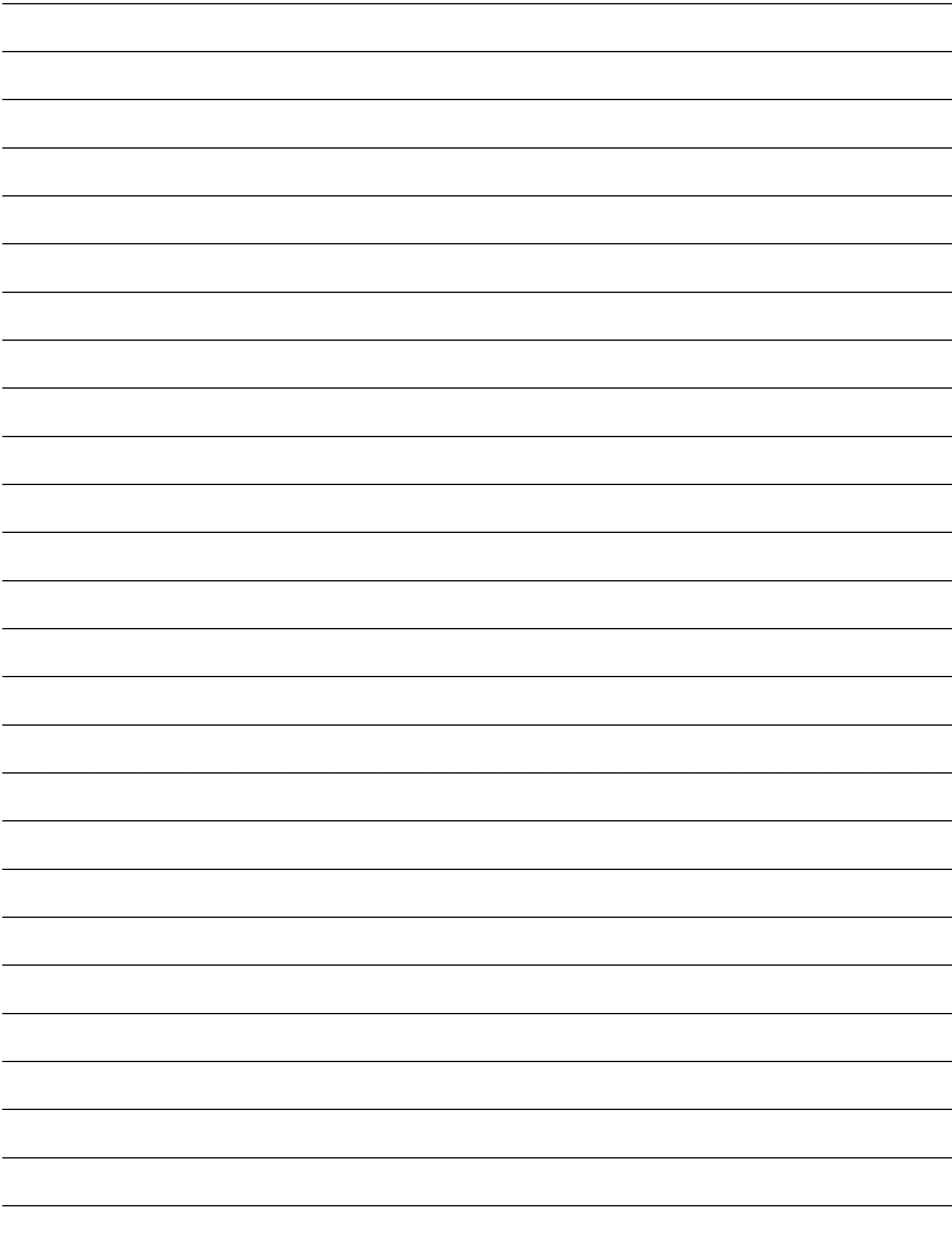
1. _____

Ambulance(s):

1. _____

2. _____

Hospital(s) and/or Clinic(s):





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The Law Office of Alan G. Bouterie & Associates

504-279-3303

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