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PERSONAL INJURY QUESTIONNAIRE

Client Information

Name							
(first)	(first) (middle)				(last)		
Date of Birth: Soc			ocial Security Number:				
Personal Contact Information							
Home Address:							
City	_State	tate		Zip			
Phone	_ Work	rk		Cell			
Email:							
Name of Work Place:							
Work Address:							
City	_ State			Zip			
Do you receive Medicare Bener	fits? Yes	No	Medi	care No			
Do you receive Medicaid Bener	fits? Yes	No Medicaid No		caid No			
Do you have Health Insurance of Name of insurance company	•	Yes	No	Is it through your:	Employer	or	Personal
Group No		Plan No		Mem	_ Member No		
Do you receive any additional i Assistance, Retirement)? If so,							
How many people reside with y How many vehicles park at you What is your relationship to the	r residence	?	``				
Do those other vehicles have se If so, with what insurance comp	parate insu	rance po	olicies f	from yours? Yes	No		

Are you currently married? Yes No	re you currently married? Yes No If yes, name of spouse							
Have you been in an accident before?	Yes	No						
Are there any other pending legal actions? Do you currently have an attorney?		No No If yes,	their name is:					
Are you currently in a bankruptcy?		No Since	when?					
If yes, which attorney is handling your bankruptcy?								
Under doctor's orders, have you missed any time from work as a result of this accident? Yes No								
Accident Information								
Date of Accident: County or City Where Accident Occurred:								
Was a police report done? Yes No	If yes,	do you have a	copy of your police report?	Yes	No			
If no, do you have the police report case nur	nber?	Yes No	The case number is					
If you have a copy of the police report, please forward it with the return of your documents.								
Name of Your Vehicle's Driver: Was the driver the owner of the vehicle? Yes No If not, who is the owner of the vehicle?								
Passengers: Yes No If yes, how m	Names:							
Insurance Information Other Vehicle/Driver: Do you have the claim number for other person's insurance company? Yes Which insurance company is the others person's vehicle insured with?								
Have you already given the other person's insurance company a recorded statement? Yes No								
Your Vehicle/Driver: Do you have insurance? Yes No Which insurance company is the vehicle ins Do you have the claim number for your insu Claim No.:	irance?	Yes	Full Coverage No					
Adjuster's Name: Adjuster's Phone Number:								

Your Vehicle's Information

Vehicle Info. (year, make, & model):			
Was your vehicle a rental car? Y If yes, then with whom (name, phone, and a	N address	(optional))?	
Vehicle Property Damage: Y N If appraised, by whom:		Amount: <u>\$</u>	
Medie	cal Tre	eatment Infor	mation
Did you go to the hospital from the scene?	Y	N If yes,	where?
If yes, did the hospital take x-rays?	Y	Ν	
Did an ambulance escort you? Yes	No	If yes, which a	mbulance service?
Have you been to any other doctors?	Y	N If yes,	please list them as follows:
Name of Facility Name	e of Doc	<u>ctor</u>	Address and Phone
			Phone:Address: