

S.A.M. LAW OFFICE LLC

Susan A. Marks, Attorney

Melissa C. Djonlich, Paralegal

Email completed for to mel@samlaw.info or fax to 847-577-2223

SOL: _____

AUTOMOBILE ACCIDENT FACT SHEET

Date Completed: _____

Background Information

Name: _____

Other names known by: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____

Mobile: _____

Email: _____

Date of birth: _____ Social Security #: _____

Driver's license number: _____

Marital status: _____

Spouse's name: _____

Employer: _____

Address: _____

Job Title: _____ How long employed? _____

Name of Supervisor: _____ Telephone: _____

Your last date worked before illness or injury: _____

Rate of Pay: _____ per _____

Date returned to work: _____

What was your total income for the most recent IRS filing: Year: ____

Total Income: _____

Did you miss work time or other benefits or income earning potential because of your Accident: Yes [] No [].

How much work time did you miss due to the accident: _____

List every claim or lawsuit in which you have been involved in any way. Include approximate year and parties involved, reasons and results.

Have you ever been arrested? _____

If yes, please provide the following information:

Date: _____ Charge: _____

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Have you ever been convicted of a crime? Yes No

If yes, please provide the following information:

Date: _____ Charge: _____

Date: _____ Charge: _____

Result (fine, penalty, supervision, etc.) _____

Have you ever been charged with a crime of fraud or dishonesty: Yes No

Have you ever been convicted of a crime of fraud or dishonesty: Yes No

Have you ever filed for bankruptcy: Yes No

Which was filed CH 7 or CH 13 (circle one)

Date of filing: _____ Date of Discharge: _____

Attorney Name: _____ Telephone: _____

Have you ever been represented by another attorney for this Accident: Yes No

Attorney Name: _____ Telephone: _____

Address: _____

Did the Attorney withdraw: Yes No

Give any other information you feel we should have to represent you effectively in this case:

Automobile Accident

Date of Injury: _____ Time: _____ Location:

_____ County: _____

Weather Conditions at time of Accident:

Where you the driver/ passenger/ pedestrian/ other (circle one).

If passenger who was driver?

Had you any alcoholic beverages at the time of the accident or shortly before: Yes No

Where you talking on your cell phone at the time of the accident: Yes No

Did any person at the accident scene appear to be intoxicated: Yes No

Name: _____

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Did you notice the driver of the other car talking on his/her cell phone before the accident occurred: Yes No

Did you speak to anyone at the scene of the accident: Yes No

Who did you speak to: _____

Where the police called? _____ Agency: _____

Was fire department called? _____ Agency: _____

Was ambulance called? _____ Agency: _____

List any citations given and to whom: _____

Describe what happened: _____

Do you have a copy of the police report: Do you have a copy of your medical records relating to the accident: Yes No

Do you have photos of your physical injuries: Yes No

Draw a diagram of the accident scene:

Are you an insured driver? Yes No

Name of your automobile insurance company: _____

Your Vehicle (Year/make/model) involved in accident:

Plate number: _____

Describe damage to your vehicle: _____

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Current Location of your vehicle: _____
Property damage resolved: _____
Were photos taken? _____ Location of photos: _____

Other vehicle involved in accident:

Name of Driver: _____
Auto insurance company: _____
Address: _____
Policy Number: _____ Claim number: _____
Adjuster Name: _____ Phone #: _____
Policy limits: _____

Other vehicle involved in accident:

Name of Driver: _____
Auto insurance company: _____
Address: _____
Policy Number: _____ Claim number: _____
Adjuster Name: _____ Phone #: _____
Policy limits: _____ Are there any witnesses to the accident:
Yes [] No [] Do you have their names and telephone numbers: Yes [] No []

Have you given a statement to any parties' insurance company: Yes [] No []
If yes when: _____ and name insurer: _____

Are you currently working with an auto insurance company to resolve your claim: Yes []
No [] If so What is the name of the person you are working _____
Telephone Number: _____
Other Adjuster Names: _____ Phone #: _____
Policy limits, if known: _____

Were you on the job at the time of the automobile accident: Yes [] No []

Name of your health insurance company: _____
Address: _____
Policyholder: _____ ID number: _____
Group number: _____ Is Policy through employer/individual

Your Injuries and Damages

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Body parts affected: _____

Describe your injury: _____

Is injury permanent? Yes No

Did death or disability result? Yes No If yes, please describe: _____

List all **INJURIES** that you received as a result of this accident.

List the names of every **HOSPITAL** you have been seen at since the accident occurred:

List the names and addresses of all **DOCTORS** who have treated you for your injuries.

List the names and addresses of all **PHYSICAL THERAPISTS** who have treated you for your injuries.

Describe every past injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.)
