

MICHAEL G. SALAZAR, P.A.
NEW CLIENT INFORMATION SHEET
(PERSONAL INJURY - GENERAL)

TODAY'S DATE _____

DATE OF ACCIDENT/INJURY _____

PERSONAL INFORMATION:

NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE () _____ DATE OF BIRTH _____

SOCIAL SECURITY #: _____ MARITAL STATUS _____

HOW LONG _____ NAME OF SPOUSE _____

ADDRESS OF SPOUSE IF SEPARATED _____

PHONE NUMBER OF SPOUSE _____

HOW LONG HAVE YOU LIVED IN FLORIDA _____

YOUR PRESENT EMPLOYER _____

EMPLOYMENT ADDRESS _____

EMPLOYMENT PHONE NO. () _____ DATE HIRED _____

DESCRIBE YOUR OCCUPATION AND TYPE OF DUTIES PERFORMED _____

HOURS YOU WORK ___ TO _____ GROSS AVERAGE WEEKLY WAGE _____

YOUR EMPLOYER ON DATE OF INJURY IF DIFFERENT FROM ABOVE _____

ADDRESS _____

DATE OF TERMINATION _____ GROSS AVERAGE WEEKLY WAGE _____

HAVE YOU LOST TIME FROM WORK DUE TO YOUR INJURIES? _____

DATE DISABILITY BEGAN _____ DATE YOU RETURNED _____

WERE YOU PAID FOR MISSED TIME? _____ BY WHOM? _____

**Thank you for your attention to these details. The more completely you fill
in this form, the more effectively we can represent you in this matter**

AT THE TIME OF THE ACCIDENT/INJURY, WERE YOU IN THE COURSE AND SCOPE OF YOUR EMPLOYMENT? _____

LIST EVERY RELATIVE LIVING IN YOUR HOUSEHOLD ON THE DATE OF THE ACCIDENT/INJURY:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO REFERRED YOU TO OUR OFFICE? _____

NAME, ADDRESS, & PHONE NUMBER OF A CLOSE FRIEND OR RELATIVE NOT LIVING IN YOUR HOUSEHOLD WHOM WE CAN CONTACT IF WE ARE UNABLE TO REACH YOU:

NAME, ADDRESS, & TELEPHONE NUMBER OF YOUR MEDICAL INSURANCE COMPANY ON THE DATE OF ACCIDENT/INJURY _____

POLICY/CONTRACT NO. _____ GROUP NO. _____

DO YOU CURRENTLY HAVE MEDICAL INSURANCE COVERAGE? _____

IF DIFFERENT FROM ABOVE, NAME, ADDRESS & TELEPHONE NUMBER OF YOUR CURRENT MEDICAL INSURANCE CARRIER _____

POLICY/CONTRACT NO. _____ GROUP NO. _____

ACCIDENT/INJURY INFORMATION:

DAY OF WEEK AND TIME _____

PLACE _____ CITY _____

WEATHER CONDITIONS IF APPLICABLE _____

IF YOU WERE INJURED ON SOMEONE ELSE'S PROPERTY, PLEASE STATE THE NAME OF THE OWNER OF THE PROPERTY: _____

OWNER'S ADDRESS _____

OWNER'S PHONE NUMBER _____ OWNER'S INSURANCE COMPANY OR
AGENT IF KNOW _____

DO YOU HAVE PHOTOGRAPHS OF THE SCENE OR YOUR ACCIDENT OR INJURY? _____

POLICE INVESTIGATION:

DID THE POLICE INVESTIGATE THE ACCIDENT? _____ WHAT DEPARTMENT? _____

CASE NO. _____ OFFICER _____

CITATION ISSUED TO: _____

CHARGE _____

DO YOU HAVE AN INCIDENT REPORT? _____

DID THE POLICE TAKE PHOTOGRAPHS? _____

WERE ANY ADMISSIONS OF GUILT MADE BY ANY PARTIES AT THE SCENE AND IF SO,
PLEASE DESCRIBE:

ANY WITNESSES TO THE INCIDENT KNOWN TO YOU:

<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE NO.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF YOU OWN WORDS, BRIEFLY DESCRIBE THE ACCIDENT/INCIDENT WHICH CAUSED YOUR
INJURIES:

INFORMATION ON YOUR INJURIES:

DESCRIBE YOUR INJURIES AND COMPLAINTS OF PAIN AS A RESULT OF THIS ACCIDENT/INCIDENT, INCLUDING AGGRAVATION OF ANY PRE-EXISTING PROBLEMS:

WAS FIRST AID GIVEN AT THE SCENE? _____

IF SO, BY WHOM? _____

LIST ALL DOCTORS, HOSPITALS, THERAPISTS, ETC., BY WHOM YOU HAVE BEEN TREATED FOR THE INJURIES SUSTAINED IN THIS ACCIDENT/INCIDENT:

<u>NAME</u>	<u>ADDRESS</u>	<u>DATES OF TREATMENT</u>

(Use back of page if necessary for more names)

LIST ANY DRUGS THAT HAVE BEEN PRESCRIBED FOR YOU BECAUSE OF THE ACCIDENT/INCIDENT:

<u>DRUG</u>	<u>PURPOSE</u>	<u>PHARMACY</u>	<u>COST</u>

DID YOU TAKE PHOTOGRAPHS OF YOUR INJURIES? _____

LIST ANY OUT-OF-POCKET EXPENSES YOU HAVE INCURRED DUE TO THIS ACCIDENT SUCH AS CRUTCHES, HEATING PAD, PROSTHETIC DEVICES, HOUSEHOLD HELP, BABY SITTING EXPENSES, MEDICAL TRANSPORTATION COSTS, ETC.

HAVE YOU GIVEN INFORMATION ABOUT THIS ACCIDENT AND/OR YOUR INJURIES TO ANY INSURANCE COMPANY? PLEASE DESCRIBE:

PRIOR ACCIDENTS OR INJURIES:

IF YOU WERE INJURED IN ANY PREVIOUS ACCIDENTS OF ANY KIND, INCLUDING AUTOMOBILE ACCIDENTS, FALLS, WORK-RELATED ACCIDENTS, ETC., DESCRIBE THE ACCIDENT AND THE INJURIES SUSTAINED AND THE AREA OF YOUR BODY THAT WAS INJURED:

LIST THE NAMES AND ADDRESSES OF ANY DOCTORS WHO TREATED YOU FOR INJURIES SUSTAINED IN ANY PREVIOUS ACCIDENTS OF ANY KINDS:

LIST ANY LAWSUITS AND/OR PERSONAL INJURY CLAIMS THAT AROSE FROM THE ABOVE-MENTIONED PREVIOUS ACCIDENTS OR INJURIES. GIVE DATES, ATTORNEYS INVOLVED, AND RESULTS:

BACKGROUND INFORMATION:

LIST ANY AND ALL PREVIOUS HEALTH CONDITIONS YOU HAVE HAD:

CRIMINAL ARREST RECORD (CONFIDENTIAL/WE NEED THIS INFORMATION TO EFFECTIVELY REPRESENT YOU)

HAS ANY OTHER LAWYER REPRESENTED YOU IN THIS MATTER? _____

ANY ADDITIONAL INFORMATION OR COMMENTS YOU FEEL WOULD ASSIST US:
