

F I T E L A W
GROUP
INJURY LAWYERS THAT FIGHT FOR YOU

INCIDENT INFORMATION SHEET

CLIENT INFORMATION

Date _____

Client Name: _____ Driver or Passenger? (please circle)

Spouse's full name, if married: _____

Address _____ City _____ State/Zip Code _____

Home # _____ Work # _____ Cell # _____

E-Mail at home _____ E-Mail at work _____

Date of Birth _____ Social Security # _____ Driver's License _____

Emergency Contact: Name: _____ Address: _____

Home # _____ Work# _____ Cell# _____ Email: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father: _____ Telephone: _____

Mother: _____ Telephone: _____

ACCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ AM or PM?

City of Incident: _____ County of Incident: _____

Road/Intersection (if applicable) _____

WERE THE POLICE CALLED TO THE SCENE? Yes ___ No ___

WAS AN ACCIDENT OR INCIDENT REPORT FILED? Yes ___ No ___

If the Police DID NOT file an Accident Report, did you obtain an exchange form? Yes ___ No ___

If yes, please state the accident or incident report number: _____

Passenger in car accident? Please give driver's full name: _____

UNDERSTANDING OF HOW THE INCIDENT OCCURRED: _____

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

NAME _____ Contact Number: _____

Address _____ City _____ State/Zip Code _____

Date of Birth: _____ Spouse's Name, if Married: _____

Driver's License: _____

INJURIES: _____

Did above go to the hospital? Yes ____ No ____ _____

Name of hospital

Transported by ambulance? Yes ____ No ____ _____

Name of ambulance service

Did they take x-rays? Yes ____ No ____

IS ABOVE SEEING A DOCTOR NOW? Yes ____ No ____ (list all Dr.'s name/address/number)

Do you anticipate any loss of earnings, due to accident related injuries? Yes ____ No ____

PROVIDER FLG REFERRED TO: _____ **(for office use only)**

PASSENGERS/COMPANIONS (if applicable): continued

NAME _____ Contact Number: _____

Address _____ City _____ State/Zip Code _____

Date of birth: _____ Spouse's Name, if Married: _____

Driver's License: _____

INJURIES: _____

Did above go to the hospital? Yes ____ No ____ _____

Name of hospital

Transported by ambulance? Yes ____ No ____ _____

Name of ambulance service

Did they take x-rays? Yes ____ No ____

IS ABOVE SEEING A DOCTOR NOW? Yes ____ No ____ (list all Dr.'s name/address/number)

Do you anticipate any loss of earnings, due to accident related injuries? Yes ____ No ____

PROVIDER FLG REFERRED TO: _____ **(for office use only)**

IF APPLICABLE: PROPERTY DAMAGE

(Damage to your vehicle)

DO YOU NEED HELP IN RESOLVING THE DAMAGE TO YOUR VEHICLE? Yes ____ No ____
(There is NO fee for this service, unless the payment of the property damage in your case is contested)

IS YOUR VEHICLE DRIVABLE? Yes ____ No ____

Estimated Damage: \$ _____

WHERE IS YOUR VEHICLE LOCATED? _____

Your vehicle's year, make, model and color: _____

Your vehicle plate number: _____

Do you have clear title to your vehicle? Yes ____ No ____

Who is the owner of your vehicle? _____

PLEASE NOTE THAT IT IS IMPORTANT WE HAVE PHOTOS OF YOUR VEHICLE AND ANY SERIOUS BODILY INJURIES. THESE PHOTOS ARE VERY IMPORTANT TO YOUR CASE.

Can you supply us with pictures of your vehicle? Yes ____ No ____, **IF NOT,**

Is your vehicle available for us to take pictures? Yes ____ No ____

IF APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your auto Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: _____

Claim Number (if known): _____

Type of Coverage: _____ MedPay Limits: \$ _____

DEFENDANT INFORMATION: IF APPLICABLE
AUTOMOBILE INSURANCE

Driver's Name: _____ Telephone Number: _____

Address: _____

Driver's Date of Birth, if known

Driver's license number, if known

Name of Insurance Carrier: _____

Agent/Adjuster: _____

Telephone Number: _____ Fax Number: _____

Policy Number (if known): _____ Claim Number: _____

DESCRIPTION OF DEFENDANT'S (other driver) VEHICLE:

Year, Make and Model: _____ Plate Number: _____

Owner's Name, if different from driver: _____

Were there passengers in the other driver's vehicle? Yes ____ No ____
If yes, how many? _____

Were there independent witnesses (individuals who were **not involved** in the accident who saw what happened?)
Yes ____ No ____

Please list the following with respect to any independent witnesses:

Name: _____ Phone Number: _____

Address: _____

Name: _____ Phone Number: _____

Address: _____

YOUR INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail: _____

Did you go to the hospital? Yes ____ No ____

Name of Hospital

Did you go by ambulance? Yes ____ No ____

Name of Ambulance Service

Did they take x-rays? Yes ____ No ____

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No ____

If yes, please list all Doctors: name, address and telephone number

FLG REFERRED TO: _____
(for office use only)

LOSS OF EARNINGS

IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING:

Employer: _____

Your position or title: _____

Rate of Pay: \$ _____ per hour or \$ _____ yearly salary

How many hours do you normally work per week? _____

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Carrier: _____

PPO, HMO, Medicaid, other (please circle one)

Name of Policy Holder: _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No ____

If yes, please state, to whom given and when: _____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS

(Please DO NOT leave blank, if none, write "None")

DATE	NATURE OF ACCIDENT OR INCIDENT (auto, work related, slip & fall, medical negligence?)	INJURIES
------	--	----------

_____	_____	_____
_____	_____	_____

How were you referred to us? (Select one)

(please describe how you came to Fite Law Group today)

Name of person who referred you: _____
their address: _____
their telephone: _____

FOR OFFICE USE ONLY

INTERVIEWER: _____

OFFICE LOCATION: _____

HOME VISIT/DOCTOR'S OFFICE: _____

DATE OF VISIT: _____

DID THE CLIENT RETAIN FLG? Yes _____ No _____

IF APPLICABLE: WRONGFUL DEATH INFORMATION SHEET

Client(s) relationship to Decedent: _____

Decedent's Name: _____

Address City State/Zip Code

Decedent's:

Date of Birth _____ Social Security # _____ Driver's License # _____

Decedent's Employer: _____

Address City State/Zip Code

Job Title/Description: _____

Salary wage rate: _____ Length of Time @ employment _____

Education: High School: Yes ___ No ___ Graduated: Yes ___ No ___; College: Yes ___ No ___ Degree: Yes ___ No ___ Post Graduate Yes ___ No ___ Degree: Yes ___ No ___

Other (Please List): _____

WAS DECEDENT MARRIED: ___ YES ___ NO

NAME OF SPOUSE: _____

CHILDREN: YES ___ NO ___

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

NAME: _____ AGE: _____

ADDRESS: _____ PHONE #: _____

IF APPLICABLE: PRODUCT LIABILITY

PRODUCT COMPLAINED OF: _____

FROM WHAT ENTITY WAS THE PRODUCT PURCHASED: _____

PLACE OF PURCHASE: _____

DATE THE PRODUCT WAS PURCHASED: _____

WHO PURCHASED THE PRODUCT: NAME: _____

ADDRESS: _____ PHONE # _____

ARE THERE PURCHASE/TRANSACTION DOCUMENTS: YES ____ NO ____

IF YES, CAN YOU SUPPLY: YES ____ NO ____

PRODUCT SPECIFIC INFORMATION:

MANUFACTURER: _____

MODEL NUMBER: _____

SERIAL NUMBER: _____

ARE THERE INSTRUCTION SHEETS, LIMITED WARRANTIES AND/OR OWNER MANUALS FOR THE PRODUCT COMPLAINED OF: YES ____ NO ____

CAN YOU SUPPLY US WITH THIS INFORMATION: YES ____ NO ____

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— G R O U P —
INJURY LAWYERS THAT FIGHT FOR YOU

PRIVACY POLICY REGARDING SOCIAL SECURITY NUMBERS

Social Security information will only be used in the event you hire the firm to represent you in your legal matter, and then only when necessary in limited use during the course of your case.

- **Social Security numbers are collected by the law firm from the client and all clients provide such information to the firm in writing.**
- **Social Security numbers are most often used to positively identify parties. Some uses may include initial service, in court orders, in orders to withhold wages for child support, in required reports filed with the State of Arizona, or to obtain retirement information used to divide retirement benefits. Most courts require Social Security numbers of all parties.**
- **All information received from a client is confidential. Numbers are not released by the firm unless authorized by the client or required in the course of representation as previously stated herein.**
- **The employees of Fite Law Group have access to this personal information.**
- **Every step is taken to protect your privacy. This information is kept secure within the offices of the firm in file folders and file drawers until such time that the file information is retired and the file removed to storage in an onsite box. Files will eventually be shredded after the time designated by the State Bar requirement for maintaining the records has expired. Social Security numbers are also kept in firm software programs that are protected by password in our system which is further protected by extensive firewalls.**

I acknowledge that I have read the above privacy information provided by Fite Law Group regarding use of my Social Security number.

Signature

Date