

PERSONAL INJURY INFORMATION SHEET

DATE : _____ REF BY: _____ O/C TV _____

D/A: _____ TYPE: _____ TIME: _____

NAME: _____

SPOUSE: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP _____

HOME # _____ CELL # _____

S.S. NO.: _____ D/O/B: _____ PLACE OF BIRTH: _____

DRIVER'S LICENSE #: _____

PRIOR ACCIDENTS: _____

PRIOR ATTORNEY: _____ PRIOR CLINIC: _____

EMPLOYER: _____ OCCUPATION: _____ WORK #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

ACCIDENT INFORMATION

LOCATION OF ACCIDENT: _____

POLICE DEPT: _____ **Miami-Dade City of Miami FHP** SEATBELTS: _____

HOW DID ACCIDENT HAPPEN? _____

MEDICAL INFORMATION

INJURIES: _____

RESCUE: YES NO TRANSPORTED NOT TRANSPORTED

HOSPITAL: _____

TREATING DOCTOR(S):

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

TEL: _____

TEL: _____

VEHICLE INFORMATION

TYPE OF CAR: _____ MODEL: _____ COLOR: _____

LOCATION OF CAR: _____

PICTURES OF CAR: _____

WITNESS INFORMATION

WITNESS: _____

TEL. NO.: _____

ADDRESS: _____

WITNESS: _____

TEL. NO.: _____

ADDRESS: _____

INSURANCE INFORMATION

1ST PARTY INS: _____

ADJUSTER: _____

TEL.: _____

POLICY NO.: _____ CLAIM NO.: _____

COVERAGE: _____ U.M. _____

3RD PARTY INS: _____

PD ADJUSTER: _____

TEL.: _____

BI ADJUSTER: _____

TEL: _____

CLAIM NO.: _____ POLICY:# _____

COVERAGE: _____

HEALTH INSURANCE: _____ POLICY NO.: _____

LOSS WAGES: _____

PROPERTY DAMAGE AMOUNT PAID: \$ _____

PAID BY: _____