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Dear Potential Client:

Attached is our Intake Form. We ask that you complete this form to the best of your ability and be as honest and thorough as possible. This information is confidential and is protected under attorney/client privilege. Upon completion of this form, return it to us at your earliest convenience. **We ask that you DO NOT fax this intake form to us.**

This information will allow us an opportunity to evaluate and make a decision regarding your claim. Please make sure you give us a current/accurate phone number and complete address so that we may contact you upon completing our review of your claim.

You can email your intake to Frontdesk@mattoxlaw.com . Please note any urgencies on the first page and allow us to contact you at our earliest opportunity to be scheduled for a free consultation.

Sincerely,

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PERSONAL INJURY/AUTO COLLISION INTAKE FORM

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE? ◯ YES ◯ NO

IF YES, PLEASE GIVE NAME OF ATTORNEY: _____

WHO WERE YOU REFERRED BY: (INDIVIDUAL, ATTORNEY, FAMILY MEMBER, SOCIAL MEDIA, BILLBOARD, COMMERCIAL, ETC.)

_____

DATE OF COLLISION/INCIDENT: _____

S.O.L.: _____

CLIENT INFORMATION:

Client's Name: _____

Client's Address: _____

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Age: _____

D.O.B.: _____ SS# _____

Employer: _____

Address: _____

Work Phone: _____ Ext.:_____

Fax: _____Workdays/Hours: _____

How long have you worked there? _____

Immediate Supervisor: _____

Spouse's Name: _____

Address: _____

_____

City: _____ State: ____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____ Occupation: _____

Prior **similar injuries**, treated medical conditions and/or symptoms to same area or current injury **(Dates/Doctors):** _____

_____

_____

_____

Prior **claims and/or settlements** (types, dates, attorneys):

_____

_____

List any **prior injury settlements**:

_____

_____

COLLISION/INCIDENT INFORMATION

Date of Collision/Incident: _____ Day of Week: _____ Time:

_____am/pm Where: (Be Specific) _____

_____

_____

Where were you coming from? _____

Where were you going? _____

DETAILS OF COLLISION/INCIDENT:

Weather condition (if happened outside): _____

Any construction in the area? _____

DESCRIPTION OF COLLISION/INCIDENT: (BE SPECIFIC – GIVE AS MUCH DETAIL AS POSSIBLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did this injury occur when you were driving a vehicle? ◯ Yes ◯ No

Were you driving a company vehicle? Yes ◯ No ◯

What was the make, model and year of the vehicle you were driving? _____

_____

Was anyone, including yourself, to the best of your knowledge, taking any medications or using any sort of drugs? ◯ Yes ◯ No

If so, please list. _____

Had anyone, including yourself, been drinking? ◯ Yes ◯ No

Did anyone make a statement at the scene? ◯ Yes ◯
No

If so, who? What was said?

To whom? _____

Were photos/videos taken of the scene of the incident? ◯ Yes ◯ No

Were photos/videos taken of collision damage to vehicles? ◯ Yes ◯ No

INSURANCE COVERAGE FOR CLIENT/PLAINTIFF:

Name of Carrier: _____

Address: _____

_____

Phone: _____

Agent's Name: _____

Address: _____

_____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount:

Uninsured Motorist Coverage Amount:

Cash Policy for Collisions:

Effective Dates of coverage:

Is this a WORKER'S COMP CLAIM?

Are you covered through your employer's insurance? ◯ Yes ◯ No

If so, provide company and agent, if known:

Policy or plan number:

Name of insured:

Limits of coverage:

Did you file a claim with your insurance company? ◯ Yes ◯ No

Has anyone from the insurance company contacted you about this claim? ◯ Yes

No If yes, name of person who contacted you:

When was the contact made?

If a statement was given, was it tape recorded or written?

Did you receive a copy? ◯ Yes ◯ No

Have you signed any authorizations to release information to anyone? ◯ Yes

No If so, identify:

Have you signed any releases? ◯ Yes ◯ No

If so, for whom?

Have you received any insurance benefits? ◯ Yes ◯ No

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? ◯ Yes ◯ No

If so, which agency?

INSURANCE COVERAGE FOR DEFENDANT

Name of Carrier: _____

Address: _____

_____

Phone: _____

Agent's Name: _____

Address: _____

_____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

MEDICAL INFORMATION:

Were you injured in this collision/incident? ◯ Yes ◯ No

If so, please describe:

_____

_____

_____

_____

_____

Were photos/videos taken of injuries? ◯ Yes ◯ No

Were photos/videos taken of the injury causing instrument? ◯ Yes ◯ No

Did you go to the hospital? ◯ Yes ◯ No

If so, which hospital: _____

Admitted or Outpatient? _____

If admitted, release date: _____

Were X-Rays taken? ◯ Yes ◯ No

Were you taken by ambulance? ◯ Yes ◯ No

Are you under the care of a physician now? ◯ Yes ◯ No

Did you miss work due to the collision/incident? ◯ Yes ◯ No

LIST DOCTORS:

1. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ◯ Yes ◯ No

Current Balance on Medical Bills: _____

2. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ◯ Yes ◯ No

Current Balance on Medical Bills: _____

3. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___◯___ Yes ___◯___ No

Current Balance on Medical Bills: _____

4. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___◯___ Yes ___◯___ No

Current Balance on Medical Bills: _____

5. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___◯___ Yes ___◯___ No

Current Balance on Medical Bills: _____

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING OR WHEN CAST IS REMOVED.

Was anyone else injured? ___◯___ Yes ___◯___ No

Who was injured? _____

Describe the injury: _____

_____

_____

Were photos/videos taken of injuries? ◯ Yes ◯ No

Were photos/videos taken of the injury causing instrument? ◯ Yes ◯ No

Did they go to the hospital? ◯ Yes ◯ No

If so, which hospital: _____

Admitted or Outpatient? _____

If admitted, release date: _____

Were X-Rays taken? ◯ Yes ◯ No

Were they taken by ambulance? ◯ Yes ◯ No

Are they under the care of a physician now? ◯ Yes ◯ No

Did they miss work due to the collision/incident? ◯ Yes ◯ No

NAME AND ADDRESSES OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WITNESSES:

1. Name and address: _____

_____

Telephone Number: (___) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___Yes ___No

2. Name and address: _____

_____

Telephone Number: (___) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___Yes ___No

3. Name and address: _____

_____

Telephone Number: (___) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___Yes ___No

4. Name and address: _____

_____

Telephone Number: (___) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___Yes ___No

5. Name and address: _____

_____

Telephone Number: (___) _____

Relationship (fellow employees, supervisors, bystanders, etc.): _____

What did each see? _____

Would they be willing to testify in court to what he/she saw? ◯ Yes ◯ No

VIEWING THE SCENE:

Can we go to the collision/incident scene? ◯ Yes ◯ No

Is the equipment available for inspection? ◯ Yes ◯ No

Who do we contact to arrange a viewing? _____

NAME AND ADDRESS: _____

_____

Telephone Number: (____) _____

Job Title: _____

Can we photograph the equipment? ◯ Yes ◯ No

Any other information you feel may assist us in representing you with this claim?

_____

_____

_____

_____

_____

_____

_____

DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): _____

_____

Sports: _____

_____

Social Activities: _____

_____

Job Duties: _____

_____

Household Chores: _____

_____

Have you had to hire domestic help? ◯ Yes ◯ No

How do you feel you have been damaged emotionally by these injuries? _____

_____

How do you feel you have been damaged financially by these injuries? _____

_____

_____

_____

DIAGRAM OF HOW COLLISION/INCIDENT OCCURRED: