

**LAW OFFICES OF
LYEM PINA P.A.**
INCIDENT INFORMATION SHEET

CLIENT INFORMATION

Date _____

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

Mr. Ms. or Mrs.

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 file a Blue 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: _____ Social Security Number: _____

Driver's License: _____ Spouse's Name, if Married: _____

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

PASSENGERS/COMPANIONS (if applicable): continued

NAME _____ Contact Number: _____

Address _____ City _____ State/Zip Code _____
Date of birth: _____ Social Security Number: _____

Driver's License: _____ Spouse's Name, if Married: _____

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 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: _____ PIP 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

REFERRED TO: _____

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, so state)

DATE	NATURE OF ACCIDENT OR INCIDENT (auto, work related, slip & fall, medical negligence?)	INJURIES
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How were you referred to us? (Circle one) I am a previous client Office sign Web Site letter Radio
TV Billboard Friend(please see below) Physician(please see below)
Phonebook: name of book _____ Other _____
(please describe how you came to Bailey & Galyen today)

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

DO YOU CURRENTLY HAVE A WILL? Yes ____ No ____
HAVE YOU BEEN DENIED SOCIAL SECURITY BENEFITS? Yes ____ No ____
HAVE YOU BEEN DENIED VETERANS BENEFITS? Yes ____ No ____
DO YOU HAVE NEED LEGAL ASSISTANCE IN AN IMMIGRATION MATTER? Yes ____ No ____

FOR OFFICE USE ONLY

INTERVIEWER: _____

OFFICE LOCATION: _____

HOME VISIT/DOCTOR'S OFFICE: _____

DATE OF VISIT: _____

DID THE CLIENT RETAIN LAW OFFICES OF LYEM PINA P.A.? Yes ____ No ____

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 Texas, 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 from the firm unless authorized by the client or required in the course of representation as previously stated herein.**
- **The employees of Law Offices of Lyem Pina P.A. 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 a locked, off-site storage facility. 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 Law Offices of Lyem Pina P.A. regarding use of my Social Security number.

Signature

Date