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**PERSONAL INJURY FILE INFORMATION**

**Date of Injury** \_\_\_\_\_

**Statute of Limitation Expires:** \_\_\_\_\_

**CLIENT:**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone (h)** \_\_\_\_\_ **(w)** \_\_\_\_\_ **(pager)** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Driver's License Number** \_\_\_\_\_ **State** \_\_\_\_\_

**Marital Status** \_\_\_\_\_ **Name of Spouse** \_\_\_\_\_

**Date of Marriage to Present Spouse** \_\_\_\_\_

**Names of Dependent Children and their ages** \_\_\_\_\_

**Name/address/relationship of nearest relative** \_\_\_\_\_

**High School and Date Graduated** \_\_\_\_\_

**College & Date Graduated** \_\_\_\_\_

**Degrees Obtained** \_\_\_\_\_

**Special Training Received** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**Name/Address of Employer** \_\_\_\_\_

**Name of Supervisor** \_\_\_\_\_

**How long at present Employer** \_\_\_\_\_

**Wage Rate** \_\_\_\_\_ **Hours/week** \_\_\_\_\_ **Overtime** \_\_\_\_\_

**Other Income** \_\_\_\_\_

**Other employers for the past 10 years** \_\_\_\_\_

**Military Service (specify)** \_\_\_\_\_

**Health Insurance Carrier** \_\_\_\_\_

**Automobile Insurance Carrier** \_\_\_\_\_

**Type/Limits of Coverage** \_\_\_\_\_

**Policy Number** \_\_\_\_\_

## ACCIDENT

Location where accident occurred \_\_\_\_\_

Were police called \_\_\_\_\_ By whom \_\_\_\_\_

Was an Accident report taken \_\_\_\_\_

Names/Badge numbers of investigating officer \_\_\_\_\_

Charges filed or arrests made \_\_\_\_\_

Were photographs taken? \_\_\_\_\_ by whom? \_\_\_\_\_

Was client rendering service for employer? \_\_\_\_\_

Name/Address of Driver of Client's Vehicle \_\_\_\_\_

Names/Addresses/Telephone numbers of witnesses \_\_\_\_\_

Has client made any statements, and if so, to whom? \_\_\_\_\_

Describe Accident \_\_\_\_\_

Time of Accident \_\_\_\_\_

Weather Conditions \_\_\_\_\_

Light Conditions \_\_\_\_\_

Objects obstructing vision \_\_\_\_\_

Type of Road (i.e., concrete, blacktop, shell, gravel, wet, dry, curved, level) \_\_\_\_\_

### Client's Vehicle

Year	Make	Body Style	License Tag No.
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Amount of Damage \_\_\_\_\_

Present location of Vehicle \_\_\_\_\_

Names/Addresses of Passengers, if any. \_\_\_\_\_

**Adverse Vehicle**

Year	Make	Body Style	License Tag No.
Owner of vehicle _____			
Name/Address/Telephone No. of Driver of adverse vehicle _____			
_____			
_____			

**CLIENT'S INJURIES:**

Parts of body and types of injuries \_\_\_\_\_

Ambulance called? \_\_\_\_\_

Medical treatment at time of injury \_\_\_\_\_

\_\_\_\_\_

Names/Addresses of Doctors \_\_\_\_\_

\_\_\_\_\_

Other relevant information about accident/injury \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL PROVIDER/EMPLOYER INFORMATION

To assist us in processing your claim, please complete this form and return it to our office as soon as possible. Providing the proper names and addresses of all providers who you have treated with as a result of this collision will help to expedite the handling of your claim.

**Client:** \_\_\_\_\_  
**Date of Loss:** \_\_\_\_\_

### Providers

Hospital or Emergency Care Center: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Ambulance: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

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Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Name of Clinic: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Dates of Treatment: \_\_\_\_\_  
Amount of Charges: \_\_\_\_\_

## Employment Information

Employer: \_\_\_\_\_  
Employers Address: \_\_\_\_\_  
Employers phone number: \_\_\_\_\_  
Occupation and Duties: \_\_\_\_\_  
Supervisor or contact person: \_\_\_\_\_  
Pay Rate: \_\_\_\_\_ Hourly/Salary \_\_\_\_\_  
If hourly, please specify the number of hours worked per week: \_\_\_\_\_  
Do you normally work overtime or have a shift differential? Yes No  
If yes, please explain: \_\_\_\_\_  
How much time did you lose from work? \_\_\_\_\_  
Please specify dates missed: \_\_\_\_\_

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date