

PI CLIENT INTAKE FORM

FILE NO.:

Attorneys Involved: Robert C. Menard | Referred By: _____

PRIMARY PLAINTIFF

Name: _____ Spouse: _____

Street Address/P.O. Box/Apt. No: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security No: _____ Birth Date: _____

EMAIL ADDRESS: _____

EMPLOYMENT INFORMATION

Client's Current Employer: _____

Street Address/P.O. Box: _____

City/State/Zip: _____ Phone No: _____

Position: _____ Hourly Wage/Salary: _____

Did you miss time off of work as a result of this accident: _____ Yes _____ No.

ACCIDENT INFORMATION

***** PLEASE BE AS SPECIFIC AS POSSIBLE *****

Date of Incident: _____ Statute of Limitations: _____

Location: _____ County: _____

Brief Description: _____

Injuries: _____

HEALTH CARE PROVIDERS

Name of Treating Physician: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

HEALTH CARE PROVIDERS

Name of Provider: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

Name of Provider: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

Name of Treating Physician: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

Name of Provider: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

Name of Provider: _____

Street Address: _____

City/State/Zip: _____ Phone No: _____

CLIENT CAR INSURANCE INFORMATION

*****VERY IMPORTANT PLEASE FILL THIS OUT*****

Insurance Company: _____ Adjuster: _____

Street Address/P.O. Box: _____

City/State/Zip: _____ Phone No: _____

Insured: _____ Claim No: _____ Policy No: _____

Type of Coverage: _____

CLIENT HEALTH INSURANCE CARRIER

PLEASE PROVIDE A PHOTOCOPY OF YOUR HEALTH INSURANCE CARD

*****VERY IMPORTANT PLEASE FILL THIS OUT*****

Insurance Company: _____ Adjuster: _____

Street Address/P.O. Box: _____

City/State/Zip: _____ Phone No: _____

Insured: _____ Policy No: _____

DEFENDANT INSURANCE INFORMATION

**** IMPORTANT PLEASE FILL OUT ****

Insurance Company: _____ Adjuster: _____

Street Address/P.O. Box: _____

City/State/Zip: _____ Phone No: _____

Insured: _____ Claim No: _____ Policy No: _____

Type of Coverage: _____

COMMENTS

Please provide a copy of the Accident Report regarding your motor vehicle accident. Please be as specific as possible. If you have never treated with a physician/hospital for this injury, please inform us. If you do not have any insurance, please also inform us. Please provide us with as much information as possible. Thank you.