CENTER FOR MILITARY LAW

PLEASE PROVIDE THE FOLLOWING INFORMATION AS ACCURATELY AND COMPLETE AS POSSIBLE. WE WILL NOT DISCLOSE ANY INFORMATION DISCLOSED UNLESS IT IS AUTHORIZED BY YOU AND PURSUANT TO WASHINGTON, D.C. AND NORTH CAROLINA STATE BAR'S RULES OF PROFESSIONAL RESPONSIBILITY. ALL INFORMATION REQUESTED IS NECESSARY TO PROVIDE OUR CLIENTS WITH THE BEST POSSIBLE REPRESENTATION. THANK YOU.

CLIENT INFORMATION

DATE:_____

PERSONAL INJURY

CLIENT : _____ _____ _____ _____

FIRST MIDDLE LAST RANK

DR. MR. MS. OR MRS. (CRICLE ONE) MAIDEN NAME: _____

SPOUSE'S FULL NAME, IF MARRIED: _____

IS IT OKAY TO DISCUSS YOUR CASE WITH SPOUSE? YES OR NO

PLEASE LIST THE PHONE NAME AND PHONE NUMBER OF EVERY PERSON YOU AUTHORIZE US TO SPEAK WITH REGARDING YOUR CASE:

_____

_____

_____

DO YOU HAVE KIDS: YES OR NO HOW MANY? _____

ARE YOU PAYING CHILD SUPPORT? YES OR NO

DO THE CHILDREN RESIDE WITH YOU? YES OR NO

PHYSICAL ADDRESS: _____

STREET

_____ _____ _____ _____

CITY COUNTY STATE ZIP

MAILING

ADDRESS: SAME AS ABOVE: YES OR NO

_____
STREET/PO BOX

_____ _____ _____ _____
CITY COUNTY STATE ZIP

ELECTRONIC ADDRESS:

PRIMARY EMAIL ADDRESS: _____@_____

WORK EMAIL ADDRESS: _____@_____

FACEBOOK: _____

TWEETER: _____

DO YOU CHECK YOUR EMAIL ON A REGULAR BASIS AND DO YOU FEEL COMFORTABLE WITH US SENDING NOTICES REGARDING YOUR CASE VIA EMAIL ONLY: YES OR NO

PHONE:

_____ _____
HOME WORK

_____ _____
CELL EMERGENCY CONTACT – NAME AND NUMBER

IF MINOR: FATHER: _____ PHONE: _____

MOTHER: _____ PHONE: _____

PERSONAL: _____-_____-_____ _____
SSN DATE OF BIRTH

_____
DRIVER'S LICENSE NUMBER/STATE OF ISSUANCE

IS YOUR LICENSE VALID: YES OR NO

EDUCATION: PLEASE CIRCLE HIGHEST LEVEL COMPLETED AND ALL APPLICABLE:

SOME HIGH SCHOOL HIGH SCHOOL GED SOME COLLEGE ASSOCIATES DEGREE

BACHELOR'S MASTERS DOCTRATE VOCATIONAL/TRADE

NAME, DATE OF COMPLETION, & LOCATION OF HIGH SCHOOL: _____

_____

_____

NAME, DATE OF COMPLETION, DEGREE EARNED, NATURE OF STUDIES IN COLLEGE/VOCATIONAL:

_____

_____

_____

EMPLOYMENT: ARE YOU EMPLOYED: YES OR NO

NAME AND ADDRESS OF EMPLOYER: _____

_____

_____

JOB TITLE: _____ LENGTH OF EMPLOYMENT: _____

DO YOU RECEIVE DISABILITY: YES OR NO SALARY? _____

ACCIDENT INFORMATION: DATE OF ACCIDENT? _____ TIME: _____ AM OR PM

COUNTY? _____ CITY? _____

ROAD/INTERSECTION? _____

WHERE THE POLICE CALLED? YES OR NO WHICH AGENCY? _____

WERE YOU A PASSENGER OR DRIVER? PASSENGER OR DRIVER

NAME OF ALL PERSONS INVOLVED IN ACCIDENT WITH YOU, PLEASE INCLUDE NAMES, ADDRESSES, INDICATE IF THEY WERE A DRIVER/PASSENGER, AND PHONE NUMBERS:

_____

_____

_____

_____

_____

DESCRIBE HOW ACCIDENT OCCURRED: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WERE YOU CHARGED WITH A TRAFFIC VIOLATION? YES OR NO

WERE THERE ANY WITNESSES OTHER THAN IN YOUR VEHICLE? YES OR NO
IF SO, STATE THEIR NAME, ADDRESSES, AND PHONE NUMBERS IF KNOWN:

_____

_____

_____

_____

_____

DID YOU GIVE A STATEMENT? YES OR NO TO WHOM? _____

INJURIES: WERE YOU TRANSPORTED BY AMBULANCE? YES OR NO WHO? _____

DID YOU GO TO THE HOSPITAL? YES OR NO WHERE?_____

WERE X-RAYS TAKEN? YES OR NO

ARE YOU BEING TREATED NOW? YES OR NO

NAME AND NUMBER OF CURRENT PHYSICIAN: _____

_____

PLEASE LIST ALL PHYSICIANS AND/OR MEDICAL PROVIDERS NOT MENTIONED ABOVE:

_____

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY SCARRING? YES OR NO WHERE? _____

DO YOU ANTICIPATE ANY LOST WAGES AS A RESULT OF ACCIDENT? YES OR NO

PLEASE STATE THE NATURE OF YOUR INJURIES: _____

_____

_____

_____

_____

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 OR NO

IS YOUR VEHICLE AVAILABLE FOR US TO TAKE PICTURES? YES OR NO

YOUR INSURANCE INFORMATION:

NAME OF YOUR AUTO INSURANCE CARRIER: _____

NAME OF POLICY HOLDER: _____

POLICY NUMBER: _____

NAME AND NUMBER OF AGENT/ADJUSTER: _____

CLAIM NUMBER (IF KNOWN): _____

DO YOU HAVE MED PAY COVERAGE: YES OR NO AMOUNT? _____

PLEASE NOT YOU MAY HAVE MEDICAL PAYMENTS COVERAGE ON YOUR POLICY. FILING A CLAIM ON YOUR AUTO INSURANCE FOR MEDICAL PAYMENTS COVERAGE WILL NOT INCREASE YOUR RATES. ADDITIONALLY, WE DO NOT TAKE ANY FEE OUT OR MEDICAL PAYMENTS COVERAGE.

DO YOU HAVE HEALTH INSURANCE? YES OR NO

NAME OF HEALTH INSURANCE CARRIER? _____

POLICY NUMBER: _____

DEFENDANT INFORMATION: (IF KNOWN):

DRIVER'S NAME: _____ TELEPHONE#:_____

ADDRESS: _____

DRIVER'S DOB: _____ DRIVER'S LICENSE#:_____

NAME OF INSURANCE COMPANY: _____

NAME AND NUMBER OF ADJUSTER: _____

POLICY #: _____ CLAIM #:_____

WAS THE DRIVER CHARGED WITH A TRAFFIC VIOLATION? YES OR NO

OTHER: HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? YES OR NO

IF SO, PLEASE STATE TO WHOM GIVEN AND WHEN? _____

MILITARY SERVICE: WERE YOU EVER A MEMBER OF THE ARMED SERVICES: YES OR NO

BRANCH: _____ RANK: _____

LENGTH OF SERVICE: _____ MOS: _____

DISCHARGE TYPE: _____ CLEARANCE: YES OR NO

UNIT: _____

PLEASE REMEMBER NOT TO MAKE ANY STATEMENTS TO ANY INSURANCE COMPANIES UNTIL YOU HAVE SPOKEN TO AN ATTORNEY. TAKE PICTURES OF YOUR INJURIES AND OF THE VEHICLES INVOLVED IN THE ACCIDENT. PLEASE BE CAREFUL OF WHAT CONTENT YOU PLACE ON ANY SOCIAL MEDIA PAGE BECAUSE IT CAN BE USED AGAINST YOU IN COURT. IN ADDITION, BE CAREFUL MADE TO MEDICAL PROVIDERS BECAUSE YOUR STATEMENTS ARE INCLUDED IN THE MEDICAL RECORDS. PLEASE BRING COPIES OF PHOTOS, INSURANCE POLICIES, ACCIDENT REPORTS, NAMES AND NUMBERS OF ADJUSTERS, AND ANY MEDICAL BILLS YOU HAVE RECEIVED WHEN YOU COME IN FOR YOUR CONSULTATION.