Signed up by: _____
Office Code: 01, 02, 03, 04
(circle one)

PERSONAL INJURY SIGN UP FORM

File No. _____
D/A: _____
S.O.L: _____
Date of Sign Up: _____

GENERAL CLIENT INFORMATION

Name: (Mr./Mrs.) _____
Spouse's Name: (Mr./Mrs.) _____
Parent/Guardian's Name: _____
Address: _____
Phone: (Home) _____ (Cell Ph.) _____
(Work) _____ (Other) _____
Email Address: _____
Date of Birth: _____ Social Sec. No.: _____
Driver's License: _____ State: ____ Expiration Date: _____
Employer: _____ Phone: ( ) _____
Address: _____
Occupation: _____ Supervisor: _____
Pay Rate: _____ Term of Employment: _____
Driver (If other than Plaintiff): _____
Driver's License: _____ (State): _____
Address: _____
Phone: (Home) _____ (Cell ph.) _____
(Work) _____
Registered Owner: _____
Address: _____

Phone: (Home) _____ (Cell ph.) _____
(Work) _____

Relationship to Client: _____
YR/Make/Color/#DRS of Car: _____
License Plate #: _____ VIN#: _____
Damage to Car: _____
_____
_____

Passenger(s): _____ _____
_____ _____
_____ _____

Auto Ins. Co.: _____
Address: _____
Phone: _____ (fax) _____
Policy#: _____ Claim #: _____
Insured: _____
Insured's Relationship to Client: _____
Effective Dates: _____
Adjuster: _____
Agent: _____
Phone: ( ) _____ fax ( ) _____
Email: _____
Address: _____

Coverages:
UM: _____ UM/PD: _____ COLL: _____ COMP: _____
LIAB: _____ MED PAY: _____ REIMBURSABLE? _____

Car Rental: _____

Health Ins. Co.: _____
Address: _____
Phone: ( ) _____ fax ( ) _____

Policy No.: _____
Group No.: _____
Claim No.: _____
Reimbursable? _____

Property Damage:

Contact made with plaintiff/defendant ins.? _____
Name: _____
Preference which Ins. Co. PD claim made: _____
Car can be seen at: _____
Phone: ( ) _____ fax ( ) _____

Photos: _____

I. ACCIDENT DATA

Date of Accident; _____ Time: _____ Weather: _____
Location: _____ (City/Co.): _____
_____
Police report made? (Yes / No) DR#: _____ Fee: $ _____
Sign up office to provide? _____ ( ) Need to request? _____
Agency's Name: _____
Agency/Address: _____
Phone: ( ) _____ Officer's Badge#: _____
Officer's name: _____
Did anyone receive a Citation/Ticket? _____ If yes, who? _____
Describe the accident: _____
_____
_____

II. DEFENDANT INFORMATION

Name: _____
Address: _____

Phone: Home ( ) _____ Cell ph. ( ) _____
Work ( ) _____
Driver license: _____ State: ____ Birthdate; _____
Registered owner: _____ Work related? _____
Address: _____ Phone: ( ) _____
Employer: _____ Phone: ( ) _____
YR/Make/Color/#DRS of car: _____
License plate #: _____ State: ____ Vin# _____
Damage to car: _____
Auto Ins. Co.: _____

Address: _____
Phone: ( ) _____ fax ( ) _____
Policy #: _____ Insured: _____
Claim #: _____
Effective Dates: _____
Adjuster: _____
Agent: _____
Address & phone: _____
_____

Coverage:
Liability Limits: _____

III. WITNESS INFORMATION

(1) Name: _____
Address: _____
Phone: ( ) _____ Cell ph. ( ) _____
Relationship to Client: _____

(2) Name: _____
Address: _____
Phone: ( ) _____ Cell ph. ( ) _____
Relationship to Client: _____

IV. INJURIES (DAMAGES)

Where: (neck, arms, head, upper/mid/lower back, hand, feet, legs, chest)

_____

_____

Type of pain: (throbbing, aches, centralized, burning, numbness, shooting, sharp)

_____

_____

Emotional: (depression, loss of sleep, stress, anxiety attack)

_____

_____

General Health Status Prior to Accident: _____

_____

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 financially by these injuries? _____
_____

V. MEDICAL TREATMENT:

Ambulance Co.: _____
Address: _____
Reference file #: _____ Phone ( ) _____
_____

Emergency room: _____
Address: _____
Reference file #: _____ Phone ( ) _____

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michael@panahlawfirm.com ; www.panahlawfirm.com

_____

(1) Doctor: _____

Address: _____

Reference file #: _____ Phone ( ) _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ☐ Yes ☐ No

Current Balance on Medical Bills: _____

(2) Doctor: _____

Address: _____

Reference file #: _____ Phone ( ) _____

_____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ☐ Yes ☐ No

Current Balance on Medical Bills: _____

(3) Doctor: _____

Address: _____

Reference file #: _____ Phone ( ) _____

_____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ☐ Yes ☐ No

Current Balance on Medical Bills: _____

(7) Any previous Accidents? _____

If so, when and what type of injuries: _____

(8) Any chronic health problems other than injuries from this accident? If so, please describe:

_____

_____

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VI. MISCELLANEOUS

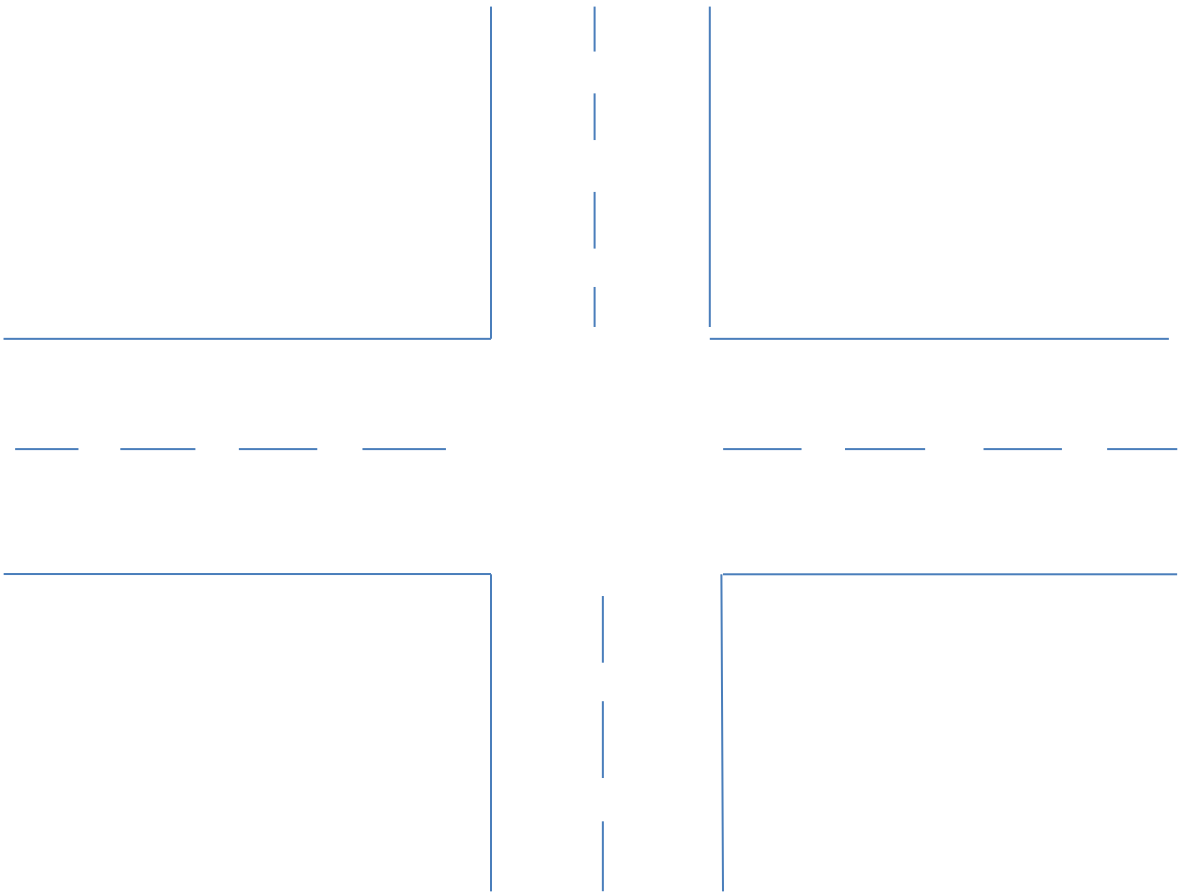
Recommendations

( ) Be sure client relates all injuries to doctor -- can't collect what you don't complaint about.;

( ) Prior Injury claims;

( ) Explanation of Legal Charges (how much, how long)

VII. DIAGRAM OF HOW ACCIDENT OCCURRED



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

_____
_____
_____
_____
_____
_____

I/We have carefully read and reviewed all of the information contained in this form as evidenced by my/our signature below, and to the best of my/our knowledge, declare under PENALTY OF PERJURY that the information is true and correct.

Client Signature: _____ **Date:** _____
Print Name: _____

Client Signature: _____ **Date:** _____
Print Name: _____

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	English/Spanish P # 2 – Minor: Yes/No	**English/Spanish P # 2 – Minor: Yes/No**	**English/Spanish P # 2 – Minor: Yes/No**
NAME:			
OTHER NAMES:			
ADDRESS:			
PHONE NO.:			
DOB:			
GOV. ID#:			
S.S.#:			
EMPLOYER:			
EMPLOYER ADDRESS:			
POS/SALARY:			
MARRITAL STATUS:			
SPOUSE OR:			
GUARDIAN:			
HEALTH INS:			
SEATED:			
INJURIES:			
AMBULANCE:			
HOSPITAL:			
CLINIC:			
CLINIC:			
WEARING SEAT BELT?	**YES / NO**	**YES / NO**	**YES / NO**
USING CELL PHONE WHILE DRIVING:	**YES / NO**	**YES / NO**	**YES / NO**
PRIOR CLIAM OR ACCIDENTS:			
OTHER INFO.:			

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