BARBUR LAW LLC

2100 SE Lake Rd. Suite 5B
Milwaukie, OR 97222
(503)654-1773
legal_assistant@barburlaw.com

# PERSONAL INJURY INTAKE FORM

## CLIENT'S INFORMATION

Full Legal Name: _____

Residence Address: _____

Phone: _____ Email:_____

Date of Birth: _____ SSN: _____

State/License Number: _____ Spouse's Name: _____

## EMPLOYER INFORMATION

Company: _____ Phone: _____

Address:_____

Salary: _____ Payroll Contact: _____

Is this a work related injury? ____ Yes ____ No

If yes, has workmans comp been filed? ____ Yes ____ No

Have you lost wages as a result of this injury? ____ Yes ____ No

Are you off work now? ____ Yes ____ No

Date you expect to return: _____

If no employer, source of income: _____

_____

## YOUR AUTOMOBILE INFORMATION

Make/Model: _____ Plate No. _____

Purchase Info: _____ Cost: _____Balance Owed:_____

Registered Owner: _____ Phone: _____

Address:_____

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**Reviewing Attorney:**_____ **Added to Matter by:**_____ **Date:**_____

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## AUTO INFO (continued)

Lienholder: _____ Phone: _____

Address: _____

Insurance Company: _____ Phone:

_____

Address: _____

Policy Number: _____ Claim Number: _____

Have you notified Insurance Company? ___ Yes ___ No

Did you need to rent a car? ___ Yes ___ No

If yes, which company? _____

## MEDICAL BACKGROUND

Have you been in an accident before? ___ Yes ___ No How many? _____

Were you injured? ___ Yes ___ No How many? _____

Was Insurance Company involved? ___ Yes ___ No

Name of Insurance Company: _____

Did you receive a settlement? ___ Yes ___ No How much? _____

Describe accident(s), Date(s) and Injuries:

_____

_____

_____

_____

_____

_____

_____

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## WORKERS COMP

Have you been in any workers comp claims? ___ Yes ___ No How many? _____

Were you injured? ___ Yes ___ No How many?

_____

Was Insurance Company involved? ___ Yes ___ No

Name of Insurance Company: _____

Did you receive a settlement? ___ Yes ___ No How much? _____

Describe accident(s), Date(s) and Injuries:

_____

_____

_____

_____

_____

_____

_____

## LIENS

Are there any parties (Medicare/Welfare) that will have a claim against the proceeds you receive as a settlement? ___ Yes ___ No

If yes, explain:

_____

_____

_____

_____

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## ACCIDENT

Type of Accident: Automobile Pedestrian Work Other

Date/time of Accident: _____ Location of Accident: _____

Your car was going (N, S, E, W) on Street: _____

Other driver was going (N, S, E, W) on Street: _____

No. Lanes Each Way: _____ Were you wearing your seatbelt? ___ Yes ___ No

Describe Incident:

_____

_____

_____

_____

_____

_____

Describe Injuries:

_____

_____

_____

_____

_____

_____

## BUSINESS WHERE ACCIDENT HAPPENED (If Applicable)

Company: _____ Phone:

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_____

Address: _____

Name of contact: _____ Title: _____ Phone: _____

**WITNESSES (If Applicable)**

Name: _____ Phone: _____

Address: _____

Relation: _____

Name: _____ Phone: _____

Address: _____

Relation: _____

**AMBULANCE (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**HOSPITAL**

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**#1**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

## HOSPITAL (continued)

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**#2 (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

## PHYSICIAN

**For Office Use Only**

**Client Name:** _____ **File Number:**_____ **Date:**_____

**Reviewing Attorney:**_____ **Added to Matter by:**_____ **Date:**_____

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**#1**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

## PHYSICIAN (continued)

**#2 (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**#3 (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

**For Office Use Only**

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Address: _____

**PHYSICAL MEDICINE (Chiropractic, Physical Therapy, Etc)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**PHYSICAL MEDICINE (Continued)**

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If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**#2 (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

**#3 OTHER (If Applicable)**

Company: _____ Phone: _____

Address: _____

Account Number: _____ Charges: _____

Submitted to Insurance Co? ____ Yes ____ No

If yes, provide insurance company information:

Company: _____ Phone: _____

Address: _____

## OTHER DRIVER INFORMATION

Full Legal Name: _____

Residence Address: _____

Phone: _____ Date of Birth: _____

## OTHER DRIVER (continued)

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State/License Number: _____

Make/Model:_____ Plate No. _____

Registered Owner: _____ Phone: _____

Address:_____

Insurance Co. _____ Policy No. _____

PIP application, have you signed/sent any forms to this insurance company? ___ Yes ___ No

**POLICE ASSISTANCE (If Applicable)**

Name of Agency: _____

Office Name: _____ Phone: _____ Date: _____

PLEASE ATTACH ALL INVOICES FOR EACH MEDICAL PROVIDER LISTED AND RETURN WITH THIS FORM

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**Reviewing Attorney:**_____ **Added to Matter by:**_____ **Date:**_____