JAVERBAUM WURGAFT
HICKS KAHN WIKSTROM & SININS, P.C.
Certified Trial Attorneys

**** PLEASE REMEMBER TO BRING THE FOLLOWING: 1. Copy of the Police Report; 2. Auto Insurance Declaration Page; 3. Driver's License; 4. Photographs of vehicles; 5. Copies of medical records and/or diagnostic testing results; 6. Any correspondence from your auto insurance company and/or the responsible party's insurance company; 7. Information about property damage/repair estimate/appraisal; 8. Health insurance card; 9. Anything else you'd like us to see.

New Client Information – Motor Vehicle

Full Name: _____ Date of Birth: _____

Social Security # _____ Email address _____

Mailing Address: _____

Cell Phone #: _____Home Phone #:_____ Work Phone #_____

Spouse Name: _____ Spouse Phone Number: _____

Children Names and Ages: _____

Which children resided with you at the time of the collision? _____

Employer (name and address): _____

Job Title: _____ Salary: _____

Date of Accident: _____ Time of Accident: _____

Location of Accident: (Road/Town/City/County/State) _____

_____

Name/address/phone # of any eyewitnesses to collision:

_____

Wearing Seatbelt? _____ Weather _____ Road Condition _____

Is there a Police Report? _____ (If Yes, please bring a copy with you to your appointment)

Name of other parties involved in accident:

_____

_____

Was there an ambulance/EMTs? _____ Did you go to a hospital? _____

If yes, which hospital? _____

Please list your treating doctors/health providers whom you saw following this accident:

Name of Dr./Provider	**Type of Doctor/Facility**	**Address**	**Dates of Treatment**
Ex.: Dr. John Smith	*Chiropractor*	*123 Main St, Newton, NJ*	*March 30 – May 11, 2020*

Please describe your injuries and any diagnoses:

_____

_____

_____

_____

Who is your primary care physician (name & address)?

_____

Who is your ObGyn physician (name & address)?

_____

Have you ever been injured in an auto accident, slip and fall, at work or in sports prior to this injury: _____

If yes, please describe the date(s), type of accident and any injuries you suffered as a result:

_____

_____

_____

Did you retain an attorney? _____ If so, please provide name & address of prior attorney:

_____

What non-accident health conditions do you have (ex. diabetes, high blood pressure, etc) ?

_____

What non-accident medications do you take?

_____

Insurance Information

(Please bring a copy of your Auto Insurance Declaration Page to your appointment.)

Auto Insurance Company: _____ Policy Number: _____

Claim Number: _____ BI/Liability Policy Limits: _____

PIP limits: _____ Is Your Health Insurance Listed as Primary?_____

UM/UIM Policy Limits: _____ Collision/Comprehensive limits: _____

Do you possess limitation on lawsuit (verbal threshold/tort threshold/lawsuit threshold? _____

Medical Insurance Provider: _____ **Policy #** _____

Other Insurance Policies: _____

Are you left-handed or right-handed? _____

Do you require corrective lenses? _____

If so, are you nearsighted or farsighted? _____ Glasses or contacts? _____

Were you wearing them at the time of the collision? _____

Name and address of Optometrist/Eye Doctor _____

How did you hear about our law firm?

_____

Thank you for completing this questionnaire. Please bring it with you to your appointment. We look forward to meeting with you.