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

**** PLEASE REMEMBER TO BRING THE FOLLOWING: 1. Copy of the Police or Incident Report; 2. Health Insurance/Medicare Policy Information; 3. Driver's License; 4. Photographs of site and injury; 5. Copies of medical records and/or diagnostic testing results; 6. Any correspondence from representatives of where you were injured; 7. Any correspondence from your insurance company or the insurance company for the responsible party.

New Client Information – Slip/Trip and Fall

Full Name: _____ Date of Birth: _____

Mailing Address: _____

Cell Phone #: _____ Home Phone #:_____ Work phone #_____

Spouse Name: _____ Spouse Phone Number: _____

Children Names and Ages: _____

Email Address: _____

Employer (name & address): _____

Date of Accident: _____ Time of Accident: _____

Location of Incident (address, town, state/apt. #/specific location of incident/lot & block #):

_____

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

Name, address, phone # of witnesses who saw what happened or came to help:

_____

_____

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*

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

_____

Who is your ObGyn physician (name & address)

_____

Please describe your injuries and any diagnoses:

_____

_____

_____

_____

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

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

_____

_____

_____

Did you hire an attorney to represent you for the prior injury? If so, what is the name & address of your 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 Health Insurance Card/Medicare Card to your appointment.)**

Medical Insurance Provider: _____ Policy #: _____

Other Insurance Policies: _____

Are you left-handed or right-handed? _____

Do you require corrective lenses? _____ If so, are you near sighted or far sighted? _____

Were you wearing your corrective lenses at the time of the incident? _____

Name & address of Optometrist/Eye Doctor: _____

What were you wearing at the time of the incident? (type of clothes, hat, coat, shoes, etc.)

_____

What if anything did you have in your hands, arms at the time of the

incident?_____

Describe the weather condition at the time of the incident? _____

Describe the lighting in the area at the time of the incident? _____

Describe condition of the area at the time of the incident? _____

How did you hear about our law firm?

_____

Thank you for completing this questionnaire. Please remember to bring it with you to your appointment.