



NEW CLIENT – PERSONAL INJURY

YOUR PERSONAL INFORMATION

Name: _____

Address: _____

Cell Phone No.: _____ Alternate phone No.: _____

Email Address: _____

Date of Birth: _____

Primary Language: _____ Need Interpreter? _____

Emergency contact (Name, Relationship, Cell Phone) _____

How were you referred to us? _____

Are you currently represented by an attorney? If so, please state their name,
phone number, and address: _____

DEFENDANT'S INFORMATION

Name, address, phone and email address of the person(s)/business(es) you
believe are responsible for your injuries: _____

Name, address, phone, policy and claim number of their insurance company _____

Name, address, phone and email address of the adjuster assigned to your file:

YOUR INSURANCE INFORMATION

Name, address and phone number of your car and health insurance: _____

Policy No. and limits of your insurance: _____

If you have Medicare or Medi-Cal coverage, please state those numbers:

ACCIDENT DESCRIPTION

Date, time and place of the accident: _____

Where were you coming from and where were you headed at the time of the accident? _____

Please describe the weather at the time of the accident: _____

How did the accident happen? _____

Name, address, phone number and email address of all witnesses: _____

If a police report was prepared, please identify the name and address of the law enforcement agency that conducted the investigation and the report number: _____

INJURIES AND TREATMENT

Please describe all body parts and medical conditions injured or caused by the accident: _____

Please state the name, address and phone of all health care facilities/providers that have treated you for this accident _____

Please state the medical expenses you have incurred from each provider as a result of this accident: _____

If you had problems with any body part injured in the accident within the last 20 years, please state the nature, extent and scope of those problems, and who treated them: _____

LOSS OF EARNINGS

Please state the name, address, and phone number of your employer(s) at the time of the accident: _____

When were you hired: _____ Your job title: _____

Your job duties: _____

How much did you make: \$ _____/hr/mo/yr Hrs/day _____ Hrs/wk _____

If you have missed time from work due to the accident, please state the dates you missed work: _____

Send completed form to newclientinfo@ghitterman.com or bring with you day of apt.