

PERSONAL INJURY QUESTIONNAIRE

Please answer each question as completely as possible. The information provided to our office is confidential and is intended only for the use of THE LAW OFFICES OF TERRY N. SILVERMAN, P.A.

Name of Client: _____ Single / Married /
Divorced
Address: _____
Phone: Home _____ Work _____ Cell/Mobile _____
Social Security Number: _____ Date of Birth: _____

Spouse Name: _____
Spouse Date of Birth: _____ Social Security No: _____

Client's Place of Employment: _____
Address: _____
Job Description _____ Length of time employed: _____
Time missed from work as a result of this accident: _____
Annual Salary: \$ _____ Supervisor name: _____

Do you have your income tax returns for the past five years? _____

Health Insurance provider: _____ ID No: _____
Do you have Medicare or Medicaid? _____ Policy No: _____

Automobile Insurance carrier: _____ Policy No: _____
Adjuster's Name : _____ Phone No: _____
Claim Number: _____ Do you carry UM coverage? Y/N; Amount \$ _____
Do you have MedPay in addition to PIP coverage? _____ Amount \$ _____
Do you have a copy of your Declarations page? _____ (please provide)

Date of accident: _____ Time of accident: _____
Location of accident : _____ City: _____
Do you have a copy of the accident report? _____ Law Enforcement Agency: _____
Were photos taken at the scene? _____ Who has the photos? _____
Do you have photos of your vehicle? _____ Was vehicle towed? _____ Totaled? _____
Location of vehicle now: _____
Describe how accident happened: _____

Any photos taken of your injury? _____ Who has the photos? _____
Describe your injuries: _____

Were there any passengers in your vehicle? _____; List names, addresses, relationship to you:

What hospital/ER did you go to? _____ Date: _____

Arrive by ambulance? _____ Doctor name: _____

Did the Doctor take you off work? _____ If so, for how long? _____

Work restrictions? _____

Were you on medication at the time of the accident? _____ What: _____

Do you wear glasses/contacts? _____ Who prescribed them? _____

When prescribed: _____ Last Date of eye examination _____

Do you wear hearing aids? _____ Who prescribed them? _____ When: _____

Were you wearing (glasses) (hearing aids) at the time of accident? _____

Have you been injured in any past accidents? _____ Date of Accident: _____

Location: _____ Injuries: _____

Please list any doctor's name and address you are being treated by, for injuries you received in the **current accident**, and list where you purchase your prescriptions:

List Doctors names and address that you have seen in the **last five years**, and the purpose of your visit:
