At Glucroft Investigations, We Uncover The Hidden

www.GlucroftInvestigations.com || info@GluInv.com || (866) 411-8646

Accident Intake Form

Before You Begin: Case Manager Best Practices

Ask all questions. Allow your client time to answer. Listen carefully and ask relevant follow up questions. If you don't have enough room for an answer, write "continued on back" and then continue on the reverse side of the page.

Law Firm: _____

Attorney's Name: _____

Address: _____

Phone: _____

Email: _____

Case Manager Name: _____

Case # _____

Date & Time of Intake: _____

Client Information

Date of Accident: _____

Time of Accident: _____

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

SSN: _____

Date of Birth: _____

Age: _____

Driver's License Number: _____

State: _____

Client's Vehicle(s)

Car Year: _____

Make: _____

Model: _____

Color: _____

Vehicle ID Number: _____

License Plate Number: _____

State: _____

R/O's Name: _____

R/O's Address: _____

Is Client the Registered Owner of the Vehicle? Yes / No

If No, Who is the Registered Owner? _____

Was Client Driving Vehicle in the Scope of Work? Yes / No (See Employer Info Below)

Damage To Your Car: _____

_____

_____

Vehicle Drivable: Yes / No

Client's Employer

Is Client Employed? Yes / No

If Yes, For How Long: _____

If Unemployed, For How Long: _____

If Unemployed, Why?: _____

If Employed, please complete the following:

Employer's Name1: _____

Address: _____

Telephone: _____

Position: _____

Present Salary: _____ Per: Month / Week / Day / Hour

Employer's Name 2: _____

Address: _____

Telephone: _____

Position: _____

Present Salary: _____ Per: Month / Week / Day / Hour

Client's Vehicle Insurance

Insurance Company Name: _____

Address: _____

Name of Insured: _____

Policy Number: _____

Claim Number: _____

Policy or Bond Period: Effective Date: _____ Expiration Date: _____

Adjuster's Name: _____

Adjuster's Email: _____

Adjuster's Telephone: _____

Adjuster's Fax: _____

Client's Coverage

Bodily Injury Liability	$ _____	Property Damage	$ _____
Umbrella	$ _____	Med/Pay	$ _____
UM/UIM	$ _____		

Client's Health Insurance

Insurance Company Name: _____

Address: _____

Telephone: _____

Name of Insured: _____

Policy Number: _____

Group / Plan Number: _____

Client's Medical Assistance After Accident

Paramedics: _____

Ambulance: _____

Hospital's Name: _____

Address: _____

Telephone Number: _____

Doctors' Names: _____

Date of Entry: _____

Description Of Client's Injuries

Description: _____

_____

_____

Bruises/Cuts: Yes / No

Describe Where: _____

_____

Was The Client Transported To A Medical Facility? Yes / No

Transported By: _____

Taken To: (Name of Facility) _____

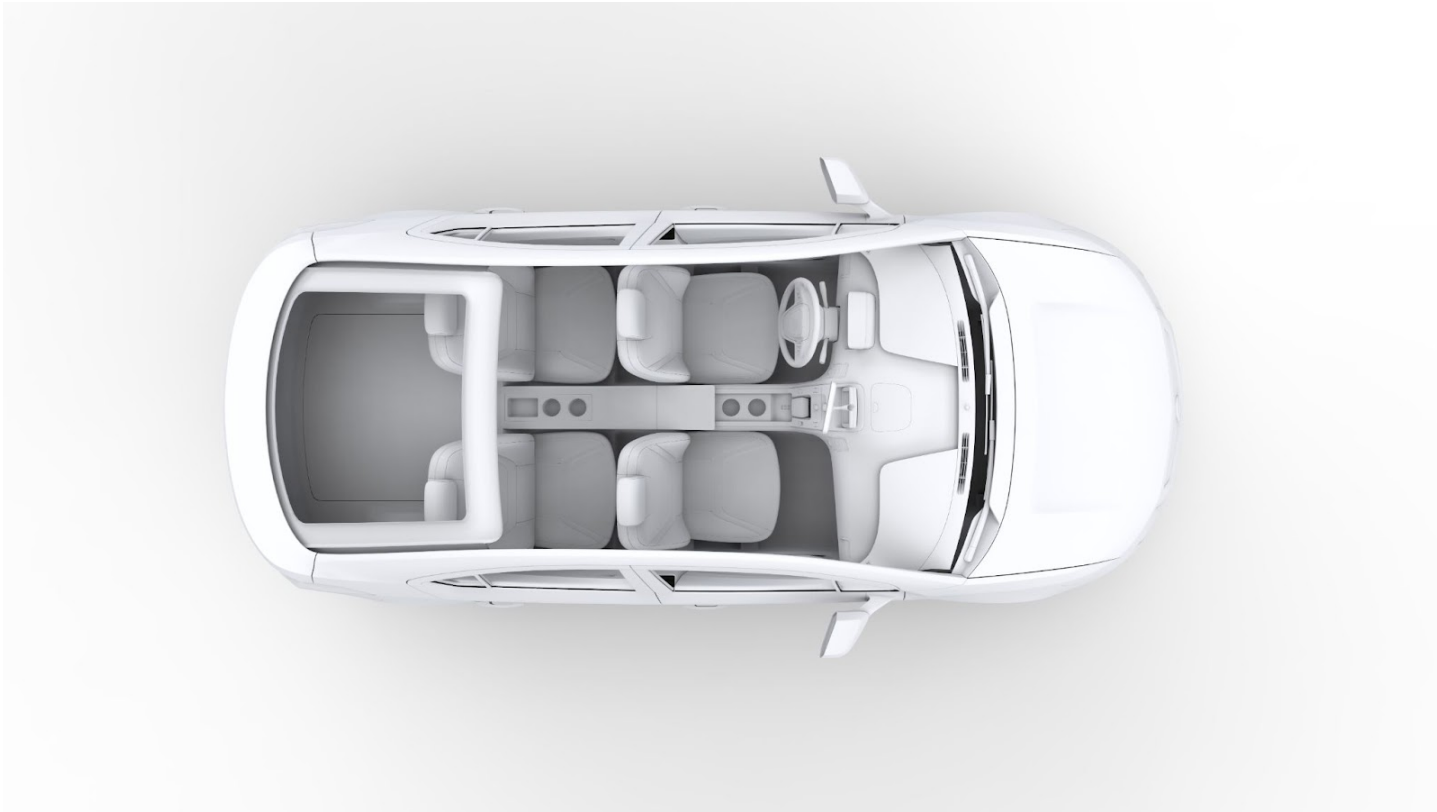
Doctor(s) You Are Seeing: _____

Treating Doctor's Address: _____

Prior Injuries: _____

Passenger's Information

Where were the passengers seated? Write a passenger number (1, 2, etc) in the drawing where they were seated. Then fill out the passenger information below.



Passenger #1:

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

SSN: _____

Date of Birth: _____

Age: _____

Driver's License Number: _____

State: _____

Seat Location In Vehicle: _____

Wearing Seatbelt: Yes / No

Employer's Name: _____

Occupation: _____

Health Insurance: _____

Policy Number: _____

Doctor: _____

Injuries (If Any): _____

_____

_____

Was The Passenger Transported To A Medical Facility? Yes / No

Transported By: _____

Taken To: (Name of Facility) _____

Passenger #2:

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

SSN: _____

Date of Birth: _____

Age: _____

Driver's License Number: _____

State: _____

Seat Location In Vehicle: _____

Wearing Seatbelt: Yes / No

Employer's Name: _____

Occupation: _____

Health Insurance: _____

Policy Number: _____

Doctor: _____

Injuries (If Any): _____

Was The Passenger Transported To A Medical Facility? Yes / No

Transported By: _____

Taken To: (Name of Facility) _____

(For additional passengers, write "see other side" and use space on the back of this sheet.)

Witnesses

Witness #1:

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

SSN: _____

Date of Birth: _____

Age: _____

Position Relative To Incident: _____

Recorded Statement: Yes / No

Date of Recorded Statement: _____

Witness #2:

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

SSN: _____

Date of Birth: _____

Age: _____

Position Relative To Incident: _____

Recorded Statement: Yes / No

Date of Recorded Statement: _____

(For additional witnesses, write “see other side” and use space on the back of this sheet.)

Accident Information

Location: _____

City: _____

Weather: _____

Number of Vehicles: _____

Police Report: Yes / No

Department: _____

Where Were You Coming From: _____

Where Were You Going: _____

What Direction Were You Traveling: _____

What Direction Was The Defendant Traveling: _____

How Many Lanes Were There: _____

What Lane Were You In: _____

What Speed Were You Traveling: _____

What Speed Was The Other Party Traveling: _____

Were You Wearing Your Seatbelt: Yes / No

Did the Other Party Have Any Passengers: Yes / No

How Many Passengers: _____

Did The Other Party Say Anything After The Accident: Yes / No

If Yes, what did they say? _____

_____

_____

Did The Other Party Speak English: Yes / No

If No, What Language Did The Other Party Speak: _____

Before The Collision, Had Your Vehicle Been:

Moving / Stopped In Traffic / Parked

Other (Explain): _____

_____

Before The Collision, Had The Other Party's Vehicle Been:

Moving / Stopped In Traffic / Parked

Other (Explain): _____

_____

How Far Away Was The Other Party When First Seen: _____

Part Of Your Vehicle First Struck: _____

Part Of The Defendant's Vehicle First Struck: _____

Who Was At Fault? Why?: _____

Other Party's Information

Full Name: _____

Gender: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Age: _____

Driver's License Number: _____

State: _____

Other Party's Vehicle(s)

Car Year: _____

Make: _____

Model: _____

Color: _____

Vehicle ID Number: _____

License Plate Number: _____

State: _____

R/O's Name: _____

R/O's Address: _____

Registered Owner of the Vehicle? Yes / No

Employers Car: Yes / No Yes / No

Vehicle Drivable: Yes / No

Damage To Other Party's Vehicle(s): _____

(For additional vehicles, write "see other side" and use space on the back of this sheet.)

Other Party's Insurance

Insurance Company Name: _____

Address: _____

Name of Insured: _____

Policy Number: _____

Claim Number: _____

Policy or Bond Period: From: _____ To: _____

Adjuster's Name: _____

Adjuster's Email: _____

Adjuster's Telephone: _____

Adjuster's Fax: _____

Other Party's Coverage

Bodily Injury Liability	$ _____	Property Damage	$ _____
Umbrella	$ _____	Med/Pay	$ _____
UM/UIM	$ _____		

Description Of The Accident

Describe accident in detail and use drawing below to illustrate the positions of the vehicles:

Diagram

- Add street names where indicated.
- Draw your vehicle and other relevant vehicles or landmarks.