Referred By____________________

Keatts & Horton, LLC., 7 Central Ave., Suite 203, Glen Burnie, MD 21061

Date Retained:__________________ Date of Accident:____________________

CLIENT'S PERSONAL INFORMATION

NAME:____
last first middle

ADDRESS:____
street apt #

____
city state zip

HOME PHONE(______)__________________________CELL PHONE (______)____________________

EMAIL: ____

SOCIAL SECURITY NO.:____________________________ DATE OF BIRTH____________________

MARITAL STATUS: ________________________ NUMBER OF CHILDREN UNDER 18:____________
(living at home)

EMPLOYMENT INFORMATION

COMPANY: ____ TITLE:________________________

SUPERVISOR: ______________________________________ PHONE: (_____)________________

ADDRESS:____

START DATE:________________________________ SALARY $______________________ PER WEEK

TIME YOU MISSED WORK DUE TO INJURIES: ____

ACCIDENT INFORMATION

LOCATION OF ACCIDENT:____

TIME OF INCIDENT:_________ AM PM WERE POLICE CALLED (PLEASE CIRCLE YES OR NO): YES NO

POLICE DISTRICT THAT REPONDED:______________________ WAS A CITATION ISSUED : YES NO

POLIC REPPORT NO.:______________ OFFICER'S NAME_________________________________

ACCIDENT INFORMATION (CONT.)

GIVE STATEMENT/DESCRIPTION OF ACCIDENT:

PLEASE LIST ALL WITNESSES:

____

____

____

PLEASE LIST ALL PASSENGERS IN YOUR VEHICLE:

____

____

____

I WAS THE DRIVER OF VEHICLE INVOLVED: YES NO

I WAS THE PASSENGER OF THE VEHICLE INVOLVED: YES NO

I WAS A PEDESTRIAN INVOLVED IN THIS ACCIDENT: YES NO

INJURY INFORMATION (please complete if you suffered injuries in this accident**)**

DESCRIBE INJURIES SUSTAINED: ______________________________

____

WHERE YOU TREATED AT THE HOSPITAL (please answer yes or no) YES NO

HOSPITAL TREATED AT :______________________________

WHERE X-RAYS TAKEN (please answer yes or no) YES NO

TREATING DOCTOR: ______________________________

MEDICATION PRESCRIBED: ______________________________

AMOUNT OF MEDICAL BILLS TO DATE: $______________________________

CLIENT/OWNER'S INSURANCE/VEHICLE INFORMATION:

DRIVER OF THE VEHICLE:

NAME:____
last first middle

ADDRESS:____
street apt #

____
city state zip

HOME PHONE (______)____________________ DRIVERS LICENSE #____________________

OWNER OF THE VEHICLE (IF DIFFERENT FROM ABOVE):

NAME:____
last first middle

ADDRESS:____
street apt #

____
City state zip

HOME PHONE (______)____________________ DRIVERS LICENSE #____________________

TAG NUMBER OF VEHICLE:____________________ VIN NUMBER:____________________

VEHICLE YEAR, COLOR & MODEL:____

IS VEHICLE DRIVEABLE YES NO

IF NO, LOCATION OF VEHICLE

____

INSURANCE COMPANY : ____

ADDRESS:____

PHONE NO.: (______)____________________ FAX NO.: (______)____________________

POLICY NUMBER: ____

ACCIDENT CLAIM NUMBER: ____

ADJUSTER'S NAME: ____

LIABILITY INSURANCE/VEHICLE INFORMATION:

DRIVER OF THE VEHICLE:

NAME:____

last first middle

ADDRESS:____

street apt #

____

city state zip

HOME PHONE (______)________________________DRIVERS LICENSE #____________________

OWNER OF THE VEHICLE (IF DIFFERENT FROM ABOVE):

NAME:____

last first middle

ADDRESS:____

street apt #

____

City state zip

HOME PHONE (______)________________________DRIVERS LICENSE #____________________

TAG NUMBER OF VEHICLE:____________________ VIN NUMBER:________________________

VEHICLE YEAR, COLOR & MODEL:____

IS VEHICLE DRIVEABLE YES NO

IF NO, LOCATION OF VEHICLE

____

INSURANCE COMPANY : ____

ADDRESS:____

PHONE NO.: (______)________________________ FAX NO.: (______)______________________

POLICY NUMBER: ____

ACCIDENT CLAIM NUMBER: ____

ADJUSTER'S NAME: ____

ADDITIONAL INFORMATION:

LIST ANY PRIOR ACCIDENTS/INJURIES YOU HAVE HAD IN THE PAST 5 YEARS AND WHAT PART OF THE BODY:

____

____

____

LIST FULL NAME OF EACH PERSON WITH WHOM YOU RESIDE AND GIVE DATES OF BIRTH, AGE AND RELATIONSHIP:

Name	DOB	AGE	Relationship
Name	DOB	AGE	Relationship
Name	DOB	AGE	Relationship
Name	DOB	AGE	Relationship
Name	DOB	AGE	Relationship

DOES ANY PERSON ABOVE OWN A VEHICLE ? YES NO

LIST EACH OWNER, VEHICLE TAG AND ALL KNOWN INSURANCE INFORMATION

OWNER		TAG NUMBER
INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

OWNER		TAG NUMBER
INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER

OWNER		TAG NUMBER
INSURANCE COMPANY	POLICY NUMBER	PHONE NUMBER