

LAW FIRM OF SHAWNDRIA MCCOY, PLLC
CLIENT INFORMATION (PERSONAL INJURY)

Date of Injury: _____ DOB: _____ SSN: _____

Name: _____
First Middle Last

Address: _____
Number/Street Apt. # City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ DL State/#: _____

Emergency Contact: _____
Name Phone number Relationship

Accident Description: _____

Investigating Agency: _____ Photos? _____

Client Ins. Co./Claim No. _____

Client's Adjuster: _____

Client's Adjuster's Phone/Fax: _____

Client's Adjuster Address: _____

Client Vehicle (Year, Make, Model): _____

Client Vehicle Location: _____

Client Vehicle Damage: _____

Defendant's Name: _____

Defendant Ins. Co./Claim No.: _____

Defendant's Adjuster: _____

Defendant's Adjuster's Phone/Fax: _____

Defendant's Adjuster's Address: _____

Defendant's Vehicle (Year, Make, Model): _____

EMS: _____ ER: _____

Family Doctor: _____ Chiropractor: _____

Radiologist: _____ Pharmacy: _____

Prescriptions: _____

Injuries: _____

Passenger 1: _____

Passenger 2: _____

Passenger 3: _____

Passenger 4: _____

Health Insurance: _____ Policy Number: _____

Medicare No.: _____ Medicaid No.: _____

Prior Accidents (Date and describe facts): _____

HOW HAS THIS ACCIDENT IMPACTED YOUR DAILY LIVING/ACTIVITIES? _____

