BAILEY & GALYEN
ATTORNEYS AT LAW

INCIDENT INFORMATION SHEET

Date_____

Client Name:_____

_____

Address City State/Zip Code

Home # _____ Work # _____ Cell # _____

E-Mail at home _____ DL # _____

Date of Birth _____Social Security # _____

Emergency Contact:_____ Cell # _____

ACCIDENT INFORMATION

Date of Incident**:** _____ Time of Incident**:** _____AM or PM?
City of Incident: _____ County of Incident: _____
Road/Intersection (if applicable) _____

WERE THE POLICE CALLED TO THE SCENE? Yes ____ No___

If yes, please state the accident or incident report number: _____

How did your accident happen? _____

_____

_____

_____

_____

_____

_____

_____

PASSENGERS INFORMATION #1:

NAME _____ Contact Number: _____

_____
Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

INJURIES:_____

Did above go to the hospital? Yes ____ No _____ _____
Name of hospital

Transported by ambulance? Yes ____ No _____ _____
Name of ambulance service

Any other medical treatment? _____

PASSENGERS INFORMATION #2:

NAME _____ Contact Number: _____

_____
Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

INJURIES:_____

Did above go to the hospital? Yes ____ No _____ _____
Name of hospital

Transported by ambulance? Yes ____ No _____ _____
Name of ambulance service

Any other medical treatment? _____

PASSENGERS INFORMATION #3:

NAME _____ Contact Number: _____

_____
Address City State/Zip Code

Date of birth: _____ Social Security Number: _____

INJURIES:_____

Did above go to the hospital? Yes ____ No _____ _____
Name of hospital

Transported by ambulance? Yes ____ No _____ _____
Name of ambulance service

Any other medical treatment? _____

IF APPLICABLE: PROPERTY DAMAGE

IS YOUR VEHICLE DRIVABLE? Yes ____ No ____ Estimated Damage: $_____

WHERE IS YOUR VEHICLE LOCATED?_____

Your vehicle's year, make, model and color:_____

Your vehicle plate number: _____

Who is the owner of your vehicle? _____

Did you take pictures of your car? Yes ___ No ___

IF APPLICABLE: YOUR AUTOMOBILE INSURANCE INFORMATION

Auto Insurance Provider:_____

Policy #:_____ Claim #: _____

Adjuster: _____ Telephone #:_____

DEFENDANT INSURANCE INFORMATION:

Driver's Name: _____ Telephone Number: _____

Address: _____

_____ _____

Driver's Date of Birth, if known Driver's license number, if known

Name of Insurance Carrier:_____ Agent/Adjuster: _____

Telephone Number**:** _____ Fax Number**:** _____

Policy Number (if known): _____ Claim Number: _____

DESCRIPTION OF DEFENDANT'S VEHICLE:

Year, Make and Model: _____ Plate Number: _____

Witnesses:_____ Telephone #:_____

YOUR INJURIES

Please describe your injuries including if you are having numbness, tingling or radiating pain:

_____

_____

_____

_____

Did you go to the hospital? Yes ____ No____ _____
Name of Hospital

Did you go by ambulance? Yes ____ No____ _____
Name of Ambulance Service

Please list all medical treatment you have received since the accident:

_____

_____

_____

_____

B&G REFERRED TO: _____
(for office use only)

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Carrier: _____

Member ID or Group NO: _____

HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE? Yes ____ No ____

If yes, please state, to whom given and when: _____

DO YOU HAVE HEALTH INSURANCE? PLEASE COMPLETE THE FOLLOWING:

Name of Insurance Carrier: _____

Member ID or Group NO: _____

Do you have any PRIOR injury claims?

When and your injuries**:** _____

_____

_____

HOW DID YOU HEAR ABOUT US?

Prior Client Family Friend Doctor Website Google Bing Yahoo Facebook Billboard

Signage WebChat Newsletter B&G Letter Radio TV Tarrant County Bar LRIS

OTHER: _____

NAME OF PERSON WHO REFERRED YOU: _____

OTHER LEGAL NEEDS:

Family Law Criminal Law Wills, Probate & Estate Planning Social Security Disability Tickets
Workers Compensation Civil Employment Law Immigration Tax Law Business
Commercial Litigation Pharmaceutical Litigation Appellate

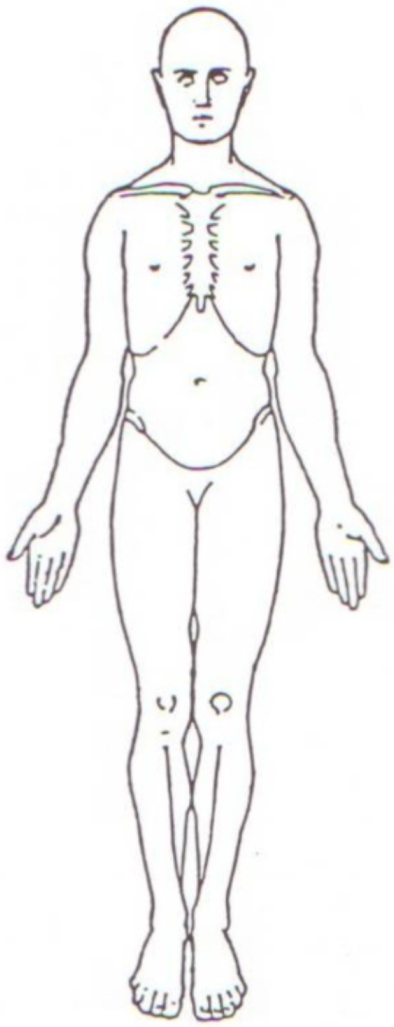
FOR OFFICE USE ONLY

INTERVIEWER: _____

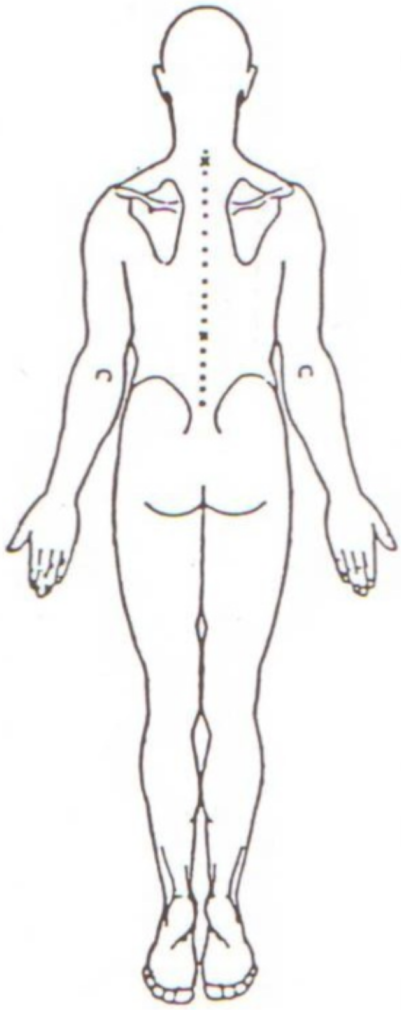
OFFICE LOCATION: _____

DID THE CLIENT RETAIN B&G? Yes _____ No _____

Please circle where you are having pain. If you are having any numbness or tingling anywhere on your body, please state so:



Front
Right Left



Back
Left Right

Side
Right

Side
Left

Bailey&Galyen
ATTORNEYS AT LAW

WAGE AND SALARY VERIFICATION FORM

Date of Accident: _____

Employer's Name: _____

Employer's Address: _____
Address City State/Zip Code

Employee Name: _____ SSN:_____

Employee Address: _____
Address City State/Zip Code

Phone Number: _____

TO THE EMPLOYER:

1. _____ Job Title of Employee
2. _____ Dates of Employment
3. Wages & Salary as of Date of Accident
   $ _____ per and _____ hours
   hour/week/month *worked per week*
4. Dates absent following accident:

   From: _____ Through: _____
5. _____ Total lost wages following accident: $

_____ Phone Number: _____
Signature. Date

Official Title: _____

Client Signature: _____