

**BAILEY & GALYEN
ATTORNEYS AT LAW
INCIDENT INFORMATION SHEET**

Premise [] Dog Bite []

Date _____

Client Name: _____

Address _____ City _____ State/Zip Code _____

Home # _____ Work # _____ Cell # _____

E-Mail at home _____ DL # _____

Date of Birth _____ Social Security # _____

Emergency Contact: _____ Cell # _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Parent/Guardian:

Name: _____ Contact Number: _____

Name: _____ Contact Number: _____

INCIDENT INFORMATION

Date of Incident: _____ Time of Incident: _____ AM or PM?

City of Incident: _____ County of Incident: _____

WERE THE POLICE CALLED TO THE SCENE? Yes ___ No ___

WAS AN ACCIDENT OR INCIDENT REPORT FILED? Yes ___ No ___

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

UNDERSTANDING OF HOW THE INCIDENT OCCURRED:

DEFENDANT INSURANCE INFORMATION:

Business/Defendant Name: _____ Telephone Number: _____

Address _____ City _____ State/Zip Code _____

Manager/Landlord Name _____

Name of Insurance Carrier _____

Agent/Adjuster: _____ Telephone Number: _____

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

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

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

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 RECEIVED SINCE THE ACCIDENT:

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

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

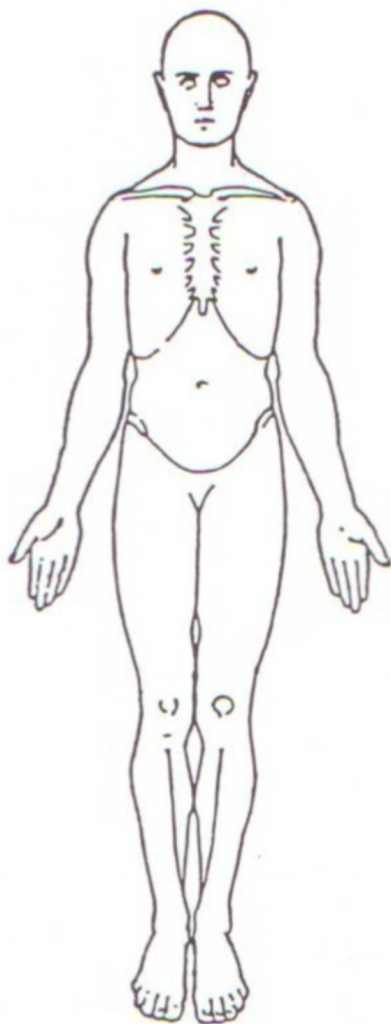
FOR OFFICE USE ONLY

INTERVIEWER: _____

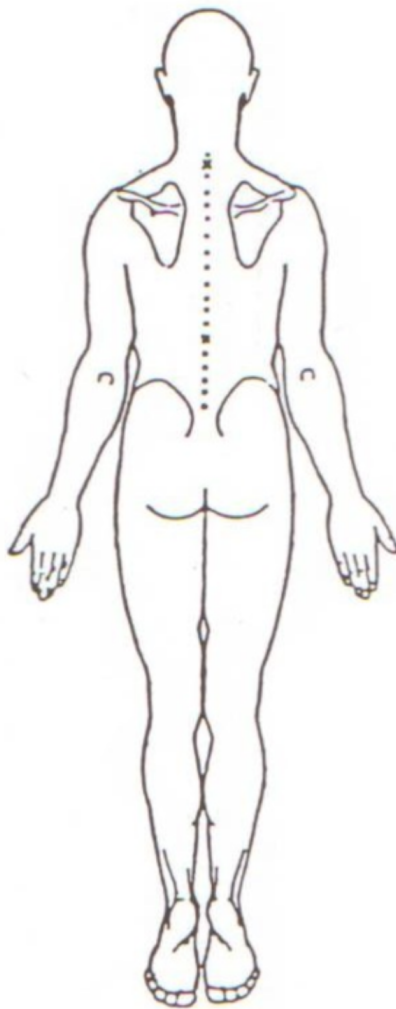
OFFICE LOCATION: _____

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



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: \$

Signature: _____ Date _____ Phone Number: _____

Official Title: _____

Client Signature: _____