CHAD BARR LAW
Raising The Bar

Chad A. Barr, Esq.
Olivia H. Miller, Esq.
Dalton Gray, Esq.
William England, Esq.
Virginia Horton Davis, Esq.

238 N. Westmonte Dr., Suite 200
Altamonte Springs, FL 32714
407.599.9036
www.ChadBarrLaw.com

NEW CLIENT INTAKE FORM

PERSONAL INFORMATION

Guardian of Injured Person, if Applicable:_____

Injured Person(s):_____ Date of Birth:_____

Social Security #:_____Driver's License #:_____

Address:_____

Ph.# (h) _____/_____ Ph.# (w) _____/_____ Ph.# (c) _____/_____

E-Mail Address/Website:_____

Additional Contact:_____

Hobbies/Activities: _____

_____

Marital Status: _____ Spouse's Name: _____

Dependent Children:_____

Criminal Convictions:_____

Prior Personal Injury or Workers' Compensation Claims? YES NO
Have you discussed this claim with another attorney? YES NO
Are you currently being represented by an attorney for this claim? YES NO
Have you given anyone a statement (in writing or verbally)? YES NO
If so, to whom was the statement given?
Who Referred You to this Firm? _____
Is this person an attorney? YES NO

Employer:_____

Address: _____

Occupation:_____ Duties: _____

Dates of Employment: Start _____ End _____

Supervisor:_____ Phone #:_____

Wage/Salary:_____ Hours per week: _____ Currently working? _____

Did you Miss Any Work Because of This Accident? YES NO

Dates Absent from Work: _____

ACCIDENT INFORMATION

Date of Accident: _____ Location of Accident: _____

City: _____ State: _____ County: _____

How did the Accident Happen:_____

_____

_____

_____

_____

_____

Were There Witnesses? YES NO

Name and Contact Info of Witness:_____

Agency Which Investigated Accident: _____

Were you wearing a seatbelt at the time of the accident? YES NO

Ambulance: YES NO Name: _____

Hospital: YES NO Name: _____

Doctors who have treated you for this accident (please list address & phone if possible):

1) _____

2) _____

3) _____

4) _____

MEDICAL HISTORY FOR THIS INCIDENT

What Injuries Were Sustained? _____

_____

_____

Any Prior Injuries to Same Part of Body: _____

Did you receive treatment for the Prior Injuries? YES NO

Name and address of doctor:_____

INSURANCE INFORMATION

Your Car Insurance Company:_____ Policy #:_____

Adjuster:_____ Phone: _____ Claim#:_____

Have you received an Application for No-Fault Benefits? YES NO

Have you spoken with any insurance agents about this accident? YES NO

When?_____

Name of Agent?_____

What did you speak about?_____

_____

Your Health Insurance Company:_____ Group/ID #:

Phone:_____ Address:_____

Has Health Insurance paid any of your claims for this accident? YES NO

Please list the names **and** ages of any relatives who reside in your household:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Year, Make and Model of all Cars Owned by You and any Person in your home:

(Yr.)	(Make)	(Model)	(Owner's Relationship to You)
(Yr.)	(Make)	(Model)	(Owner's Relationship to You)
(Yr.)	(Make)	(Model)	(Owner's Relationship to You)

Who Caused The Accident: (commonly listed as "Driver" on Crash Report)

Name _____ Driver's License No. _____

Address _____

Phone No. _____ Vehicle Tag No. _____

Insurance Carrier _____ Adjuster _____

Insurance Company Address _____

Policy No. _____ Claim No. _____

Who Owned the Vehicle that hit you? (commonly listed as "Vehicle Owner" on Crash Report)

Name _____ Driver's License No. _____

Address _____

Phone No. _____ Vehicle Tag No. _____

Insurance Carrier _____ Adjuster _____

Insurance Company Address _____

Policy No. _____ Claim No. _____

CONFIDENTIAL INFORMATION REGARDING PRIOR INJURIES/ACCIDENTS

I. Prior Injuries & Accidents

A. Prior Injuries Requiring Medical Attention (regardless of whether the injuries are the same or similar)

1. Date of Injury:

What was Injury:

How Did Injury Occur:

Treating Drs. for that injury: