



Law Offices of

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To prepare for your Personal Injury or Auto Accident Consultation, please fill out this form to the best of your ability. If you do not know the answer, skip it and fill out the rest of the form with as much information as you have, or are comfortable with giving at this time.

### **Personal Information**

Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Social Security: \_\_\_\_\_

DOB: \_\_\_\_\_ DL Number: \_\_\_\_\_

E-mail : \_\_\_\_\_

### **Incident Information**

#### **1. Your Vehicle**

Auto Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Make / Model / Year of Vehicle: \_\_\_\_\_

#### **2. Your Medical Information**

Medical Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Please Note: No attorney-client relationship is established by the use of this form. Nothing on this page should be used as legal advice.



### 3. Additional Vehicles Involved

Driver Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ DL Number: \_\_\_\_\_

Auto Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Make / Model / Year of Vehicle: \_\_\_\_\_

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Driver Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ DL Number: \_\_\_\_\_

Auto Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Make / Model / Year of Vehicle: \_\_\_\_\_

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Driver Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ DL Number: \_\_\_\_\_

Auto Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone Number:(\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Make / Model / Year of Vehicle: \_\_\_\_\_



**4. Description of the Incident**

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Names and Phone Numbers of Witnesses:

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**5. Medical Care**

Were there any injuries? If so please describe: \_\_\_\_\_

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Did anyone get transported by ambulance or helicopter?

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Was the other driver hospitalized?

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List all Physicians, Emergency Rooms, Clinics, and Therapy attended that is related to the incident (Name of Facility, dates attended, phone number):

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**6. Additional Information**

Did you take photos of the accident, cars, and injuries: \_\_\_\_\_

Has your car been repaired? If so, please provide date(s) and invoice(s):

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