



**LAW OFFICES OF  
LAWRENCE L. WASHBURN, III, P.C.**

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LAWRENCEVILLE, GEORGIA 30045  
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**PERSONAL INJURY INTAKE FORM**

Date:

Name:

First

Middle

Last

**CONTACT INFORMATION**

Address:

City:

County:

Zip:

E-Mail:

Phone #:

Home

Work

Cellular

Please place a check next to the phone number where it is best for use to contact you.

How long have you lived at your current address?

**GENERAL INFORMATION**

Are you married? y/n  Have you ever been divorced?   
Does your spouse live at the same address you provided above? y/n  If not, provide below:

Address:

City:  County:  Zip:

E-Mail:

Phone #:    
Home Cellular

How many children do you have?   
Please list the name and date of birth of all your children:

Child's Name:	<input type="text"/>	DOB:	<input type="text"/>
Child's Name:	<input type="text"/>	DOB:	<input type="text"/>
Child's Name:	<input type="text"/>	DOB:	<input type="text"/>
Child's Name:	<input type="text"/>	DOB:	<input type="text"/>
Child's Name:	<input type="text"/>	DOB:	<input type="text"/>

**INSURANCE INFORMATION**

Were you involved in a car accident? y/n  Please list the following about your policy:

Did you own the car you were in at the time of the accident? y/n

If not, who owned the car you were in at the time of the accident?

Please provide your insurance information, or the information for the vehicle in which the accident occurred.

**YOUR INSURANCE**

**CAR OWNER INSURANCE**

Company

Company

Policy #

Policy #

Effective Dates of Coverage

Effective Dates of Coverage

Name on Policy

Name on Policy

Cars Covered

Cars Covered

Listed Operators

Listed Operators

Liability Limits

Liability Limits

Uninsured Limits

Uninsured Limits

Medical Limits

Medical Limits

Please bring a copy of the declaration sheet and the actual insurance policy.

Are you related to the person that owned the vehicle involved in the accident?

Do you reside with the person that owned the vehicle involved in the accident?

Do you have health insurance, medicare, medicaid, ect?

Health Insurance Provider

Policy #

Limits of Policy

Do you know the insurance provider for the party that caused the accident?

Company  Name on Policy

Do not contact the other party or their insurance company - your attorney will contact them.

Has anyone contacted you from the other party's insurance company?

### THE INCIDENT AND INJURIES

Date of Incident:

Time:

City:

County:

Location of Incident:   
(Intersection)

Give a description of the accident in your own words:

Were the police called to the scene of the accident?  y/n  Was a report made?

Were you under the influence of any drugs or alcohol at the time of the accident?

Was the other party under the influence of any drugs or alcohol?

**\*\*Please bring a copy of the police report to your initial consultation.**

Name of the person that caused the accident:

Address of person that caused the accident:

City:

State:

Zip:

Give a description of any personal injuries suffered in the incident:

Were you taken to the hospital in an ambulance as a result of the incident?

Have you been to the doctor since the time of the incident?

**\*\*Please bring a copy of any doctor's bills to your initial consultation.**