

Please answer this questionnaire as completely as you can. Providing the information is time well spent. Our ability to represent you and your case depends on the accuracy and completeness of your answers.

AUTO ACCIDENT CLAIM

1. Personal information

Name:

Age:

Marital status:

Number of Children and ages:

Address:

City, State, Zip Code

Phone:

Email Address:

Myspace, Facebook etc... Address:

Driver's License Number and State:

Employer:

Street Address:

City, State, Zip Code:

Telephone number:

Job Title:

Gross salary per month or annually:

Length of employment:

Do you have Auto Insurance?

If so, what is the name of your Auto Insurance?

Do you have full or liability auto coverage?

NEGLIGENCE ISSUES

- 1. Who do you feel was negligent? Include names, addresses, phone numbers, and insurance company names of each driver involved.**

Driver #1:

Driver #2:

Driver #3:

- 2. When did the accident occur?**
- 3. Where did the accident occur?**
County:
- 4. Explain how the accident occurred.**

- 5. Was an accident/police report done?** Please attach a copy.

INJURIES AND DAMAGES

List all physical injuries you sustained as a result of this incident:

List any and all emotional injuries sustained:

List any and all other disabilities (learning, cognitive, emotional, to others) sustained by you as a result of the negligence and what (if any) special measures are needed to make up for these disabilities. Please also include whether these disabilities are ongoing and what impact they have had on you and your family.

1. **Please give an estimate of the total amount of the medical bills incurred on your behalf.**
2. **Do you have health insurance? If so, what is the name of the insurer?**
3. **Has your health insurance paid your medical bills? If so, please provide us with a copy of your insurance policy.**
4. **Did Medicare pay any of your claim related medical bills? If so, please provide Medicare number:**

If so, do you have Part A and/or Part B?

5. **Did Medicaid pay any of your claim related medical bills? If so, please provide Medicaid number:**

5. **What medical bills are outstanding?**

7. **Please give an estimate of the total amount of wage income lost as a result of the injury.**

11. **Please provide the following information about any health care providers, including doctors, hospitals and clinics, (other than those at fault) who have or are now caring for you:**

Provider:

Address and phone:

When was care given:

Reason for care:

Provider:

Address and phone:

When was care given:

Reason for care:

12. What are your expectations in this case?

13. Have you spoken or corresponded with any other attorneys regarding this matter?
If so, who?

ADDITIONAL INFORMATION

1. How were you referred to this office?

**PLEASE MAKE NOTE THAT YOU ARE TO CALL OUR OFFICE TO INSURE ANSWERS TO
QUESTIONS HAVE BEEN RECEIVED**

Under current Texas law, you appear to have two (2) years from the date of occurrence in which to file a lawsuit. However, the Texas Supreme Court periodically changes the law and circumstances affecting the statute of limitations for various types of cases, which may effect when the statute of limitations in your particular case will run. Remember – under Texas law you are forever prevented from filing a lawsuit unless it is done within the deadlines set out above.

Our office will be in contact with you (*via email/phone*), with decision within 30 days from the date answers are received.

Sincerely,

Ruth E. Richards
Legal Administrative Assistant
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I AM IN THE OFFICE MONDAY THRU THURSDAYS FROM 8:00 AM TO 4:00 PM