

**CLIENT INFORMATION FOR PERSONAL INJURY CLIENTS OF
RICHARD B. MEYERS AND BRENDA K. NEVILLE**

GENERAL INFORMATION

NAME: _____

ADDRESS: _____

PHONE NUMBER: HOME _____ WORK _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: _____

SPOUSE'S NAME: _____

CHILDREN'S NAMES AND BIRTH DATES: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

OCCUPATION OR TITLE: _____

WAGE RATE: _____

TIME LOST FROM WORK: _____

SPOUSE'S EMPLOYER: _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

OCCUPATION OR TITLE: _____

WAGE RATE: _____

TIME LOST FROM WORK: _____

INSURANCE INFORMATION

IS DEFENDANT INSURED? ___ Yes ___ No IF SO:

NAME OF INSURANCE COMPANY: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

NAME OF ADJUSTER: _____

POLICY LIMITS: _____

ARE YOU INSURED? ___ Yes ___ No IF SO:

NAME OF INSURANCE COMPANY: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

NAME OF ADJUSTER: _____

POLICY LIMITS: _____

DO YOU HAVE UNINSURED/UNDERINSURED COVERAGE? _____

DO YOU HAVE MED PAY? _____

DO YOU HAVE ANY OTHER MEDICAL/HOSPITALIZATION INSURANCE? IF SO

NAMES AND ADDRESSES OF EACH: _____

DID YOU HAVE ANY MEDICAL PROBLEMS PRIOR TO THE ACCIDENT? ____ Yes

____ No

IF SO PLEASE LIST THE PRE-EXISTING CONDITIONS: _____

HAVE YOU HAD ANY PRIOR INJURIES OR CLAIMS? ____ Yes ____ No

IF SO PLEASE LIST: _____

HOW HAS THIS ACCIDENT EFFECTED YOUR QUALITY OF LIFE (I.E. PAIN AND SUFFERING)? _____

DO YOU WEAR GLASSES? ____ Yes ____ No

DOES THE OTHER DRIVER WEAR GLASSES? ____ Yes ____ No

WERE YOU TAKING MEDICATION AT TIME OF THE ACCIDENT? ____ Yes ____ No

WAS THE OTHER DRIVER TAKING MEDICATION AT TIME OF ACCIDENT? ____ Yes
____ No

WERE YOU WEARING YOUR SEAT BELT? ____ Yes ____ No

WAS THE OTHER DRIVER WEARING HIS SEAT BEAT? ____ Yes ____ No

INFORMATION REGARDING INJURIES AND DAMAGES:

DESCRIBE THE IMPACT AND EXPLAIN HOW IT AFFECTED YOUR BODY (I.E.
TYPE OF MOTION): _____

YOUR INJURIES: _____

DIAGRAM OF THE ACCIDENT:

TYPE OF CAR AS WELL AS DESCRIPTION OF DAMAGE: _____

DEDUCTIBLE: _____

HAS YOUR CAR BEEN REPAIRED? ____ Yes ____ No

PASSENGERS IN YOUR CAR: _____

NAME OF OTHER DRIVER: _____

ADDRESS OF OTHER DRIVER: _____

PHONE NUMBER OF OTHER DRIVER: _____

TYPE OF CAR HE/SHE WAS DRIVING: _____

OWNER OF OTHER CAR: _____

LICENSE NUMBER OF OTHER CAR: _____

OTHER DRIVER'S INSURANCE COMPANY AND/OR ADJUSTER: _____

PASSENGERS IN OTHER DRIVER'S CAR: _____

INDEPENDENT WITNESSES: _____

HAVE YOU SERVED IN THE ARMED FORCES? ____ Yes ____ No

WHEN? _____

HAVE YOU EVER BEEN ARRESTED? ____ Yes ____ No

WHEN? _____

WHAT WAS THE CHARGE? _____

WERE YOU CONVICTED? ____ Yes ____ No