LAW OFFICES *of*
# DAVID D. WHITE
ATTORNEY AND COUNSELOR AT LAW
10535 Main Street, Clarence, New York 14031
Phone: (716) 759-1500 ♦ Fax: (716) 759-2117
Email: ddw@davidwhitewnylaw.com
*Also Admitted in Florida*

## INCIDENT INFORMATION FORM

### I. Basic Client Information

Client Name: _____ Driver □ Passenger □

Spouse's full name, if married _____

Home Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security #: _____ Driver's License #:_____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Email: _____ , _____

Emergency Contact: (Name) _____ (Address) _____

Phone #: _____

**If client is a minor under NYS law, please complete:*

Father's Name: _____ Mother's Name: _____

Telephone #: _____ Telephone #: _____

### II. Accident Information

Date of Incident: _____

Time of Incident: _____

Location of Incident: _____ _____ (physical location)

_____ (address, if any)

Street City State Zip Code County

Police Called to Scene?: YES ☐ NO ☐

Report Filed? YES ☐ NO ☐ (Type?: _____) (By whom?: _____)

To your recollection, how did the incident in question transpire?

_____

_____

_____

_____

_____

_____

**PASSENGER INFO**: Who was with you? (if this applies):

Name: _____

Address: _____

Street City State Zip Code

Phone: _____

Date of Birth: _____

Driver's License #: _____

Injuries They Sustained (if any): _____

Was this individual transported to a hospital? YES ☐ NO ☐ Hospital Name: _____

Was this individual transported by an emergency vehicle? YES ☐ NO ☐ Service Name: _____

Is this individual currently seeing a doctor in relation to injuries sustained? YES ☐ NO ☐

Do you anticipate any loss of earnings, due to accident-related injuries? YES ☐ NO ☐

**VEHICULAR/PROPERTY DAMAGE INFO**:

Is your vehicle drivable?: YES ☐ NO ☐

What is the estimated damage amount?:$ _____

*VEHICLE INFO*:

Make: _____

Model: _____

Year: _____

VIN #: _____

Plate #: _____

*Is the TITLE on your vehicle clear?* YES ☐ NO ☐

*Who owns the vehicle in question?* _____

Do you currently have pictures of your vehicle following the incident? YES ☐ NO ☐

Is your vehicle available for us to take pictures? YES ☐ NO ☐

**AUTO INSURANCE INFO:**

Name of your auto Insurance Carrier: _____

Name of Policy Holder: _____

Policy Number: _____

Agent/Adjuster: _____

Telephone Number: _____

Claim Number (if known): _____

Type of Coverage: _____ PIP Limits: $ _____

## III. Post-Incident Information

**YOUR INJURIES**

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail:

_____

_____

_____

_____

Did you go to the hospital? YES □ NO □

Name of Hospital _____

Did you go by ambulance? YES □ NO □

Name of Ambulance Service _____

Did they take x-rays? YES □ NO □

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE INCIDENT, OTHER THAN AT THE EMERGENCY ROOM? YES □ NO □

If yes, please list all Doctors: Name, Address and Telephone Number

_____

_____

**LOSS OF EARNINGS** (*IF YOU ANTICIPATE LOSS OF EARNINGS DUE TO ACCIDENT RELATED INJURIES, PLEASE COMPLETE THE FOLLOWING):*

Employer: _____

Your position or title: _____

Rate of Pay: $ _____/ hour -or- $ _____/year (salary)

How many hours do you normally work per week? _____

**DO YOU HAVE HEALTH INSURANCE?** (*IF YES, PLEASE COMPLETE THE FOLLOWING*):

Name of Insurance Carrier: _____

(please circle one) PPO HMO Medicaid Other _____

Name of Policy Holder: _____

**HAVE YOU GIVEN A RECORDED STATEMENT TO ANYONE?** YES □ NO □

**If yes, please state, to whom given and when: _____**

**_____**

**_____**

**ANY PRIOR ACCIDENTS (not solely automobile) OR INCIDENTS FOR ALL CLIENTS** (***Please DO NOT leave blank, if none, write "NONE"***)

DATE / NATURE OF ACCIDENT OR INCIDENT / INJURIES SUSTAINED / TYPE (auto, work related, slip & fall, medical negligence)?

_____

_____

_____

_____

***How were you referred to us? (Please circle one)***

I am a previous client Office sign Web Site Erie County Bar Association Referring Attorney

Former/Current Client

Name of person who referred you: _____

Their address: _____

Their telephone: _____