Law Offices of George R. Brezina, Jr., P.A.

Confidential Client Questionnaire

MOTOR VEHICLE ACCIDENT

The information, answers represented below and responses provided below are truthful and made to the best of my memory. Executed under penalties of perjury by:

____
Signature and Date

Thank you for your confidence in selecting **Law Office of George R., Brezina, Jr., P.A.** to represent you in your personal injury claim. In order to most effectively represent you, we must obtain the following information. Please complete this form as fully as possible. All information provided to this law firm is protected by the attorney-client privilege. We appreciate your effort in completing this form.

1. Last name: ________________ First name: ______________ MI: ______

2. Age _____ Date of birth: __________ Social Security #: ______________

3. Driver's License/ID No.: __________________________ State ________

4. Telephone Numbers:
   - (Home): ________________________
   - (Work): ________________________
   - (Cell): ________________________
   - (Fax): ________________________
   - (E-mail address): ________________________

5. Home Address:
   - Street ________________________________
   - Apt #: ________________________________
   - City, State & Zip Code: ________________________

6. Name, Address and Telephone Number of a person (not living with you) to contact in case of and emergency: ______________________________

____

ACCIDENT INFORMATION

7. Date of Accident: ______________

Day of week: ______________

Time: ______________ AM ____ PM ____

8. Location (Be as specific as possible): ______________________________

____

9. Describe details of the accident: ______________________________

____

____

____

10. Did any police agency investigate the accident? ______ Yes ______ No

If so, which department? TPD ______ SD ______ FHP ______ Other ______

11. In which county did the accident happen? ______________________________

What is the police report number? (**this is required)** ______________

Did anyone receive a ticket as a result of this accident? _____ Yes _____ No

If so, who received the ticket and what was it for? ______________________________

____

12. Were there any passengers in your vehicle? _____ Yes _____ No

If so, list the names, addresses, and telephone numbers of each passenger: __________

____

____

13. Do you know if there were any witnesses (other than your passengers) to the accident?

_______ Yes _____ No

If so, list the names, addresses, and telephone numbers of all witnesses to the accident.

____

____

____

14. Please give us any statement you heard the Defendant make about the incident, or that you understand that he/she may have made.

____

____

15. Describe **all** injuries you sustained as a result of the accident: ____________________

____

Were any photos taken of your bodily injuries? Yes No If so, name & ph# of person who took the photos & date photos taken:

____

____

16. Did an ambulance come to the scene? _____ Yes _______ No

If so, what was the name of the Ambulance/EMS? ____________________________

17. Did you receive treatment at the scene? _____ Yes _______ No

18. Did the ambulance transport you to the emergency room? _____ Yes _____ No

If so, which hospital were you taken to? ____________________________________

19. Were x-rays taken at the hospital? _____ Yes _______ No

20. Please list ***ALL*** of the Doctors and any other Medical Facilities you have been to as a result of the accident (include address and telephone number, if known):

a. Name: ____

Address: ____

Telephone Number: ____________________________________

b. Name:

____

Address: ____________________

Telephone Number: ____________________

c. Name: ____________________

Address: ____________________

Telephone Number: ____________________

d. Name: ____________________

Address: ____________________

Telephone Number: ____________________

e. Name: ____________________

Address: ____________________

Telephone Number: ____________________

21. Make, Model, Year of ***your*** vehicle.
Describe the damage done to ***your*** vehicle: ____________________

____

____

22. Has your vehicle been repaired? _______ Yes _______ No

If yes, who paid to repair your vehicle? ____________________

____

23. Has your vehicle been considered a total loss by anyone? _____ Yes _____ No

If so, have you been paid for your vehicle? _____ Yes _____ No

24. Where is your vehicle now? ____________________

25. Make, Model, Year of the ***other*** vehicle(s):
Describe the damage to the ***other*** vehicle(s): ____________________

26. Has anyone taken photographs of any of the vehicles involved in this accident?

_______ Yes _______ No _______ Uncertain

If yes, Name & ph# of person who took photos: ____________________

EMPLOYMENT INFORMATION

27. Name of your employer at the time of the accident: ______________________________

    Employer's Address: ____

28. How long had you worked for this employer prior to the accident? ________________

29. Job title at the time of the accident: ____

30. Duties: ____

    ____

    ____

31. Rate of pay at the time of the accident: ______________________________________

32. Have you missed any time from work as a result of the accident? ____ Yes ____ No

    If yes, please list the dates and reasons you were unable to work:

    Date   Reason Unable to Work

    ____

    ____

33. Did you lose any wages? ________ Yes ________ No

    If so, what is the total amount of your lost wages at this time? ____________________

34. Have you used vacation or sick time to avoid losing wages? _____ Yes ______ No

35. Have you changed jobs since the accident? _____ Yes ______ No

    If yes, please list why and the name and the address of our new employer:

    ____

    ____

INSURANCE INFORMATION

36. Do you know whether the person/business causing your injuries was covered by any type of insurance? ______ Yes ______ No ______ Uncertain

    If so, what is the name of the insurance company? ______________________________

37. What is the claim number? ______________________________

38. Have you spoken with anyone from the insurance company? ______ Yes ______ No

39. Did anyone take a recorded statement from you? ______ Yes ______ No

40. What is/was the name of ***YOUR*** automobile insurance company at the time of the accident? ______________________________

41. Have you notified ***YOUR*** automobile insurance company of this accident?

    ______ Yes ______ No

42. What is the telephone number of ***YOUR*** automobile insurance company's claim department? ______________________________

43. What is/was ***YOUR*** automobile insurance policy number at the time of the accident?

    ____

44. Has ***YOUR*** automobile insurance company provided you with a Claim Number?

    ______ Yes ______ No If so, what is the claim number? ______________________________

45. Have you completed a PIP application? ______ Yes ______ No

46. Have you made a claim to ***YOUR*** automobile insurance company for lost wages?

    ______ Yes ______ No

47. Were you covered by any type of **HEALTH INSURANCE** at the time of your accident or at any time since your accident? ______ Yes ______ No

    If so, what is the name of the health insurance company? ______________________________

    Insurance Policy Number: ______________________________

    Type of Coverage: ______ PPO ______ HMO ______ Medicare ______ Medicaid

    Telephone number of claims department: ______________________________

LIENS

48. Have you ever made an application to the State of Florida or your County of residence for financial assistance in the payment of rent and/or utilities, etc.? ___ Yes ___ No
If yes, was assistance received? Who provided assistance? Amount provided? ________
____

49. Have you filed for bankruptcy within the last 7 years? ______ Yes ______ No
If yes, what was the date filed and discharged? ______________________________
Please provide name, and address of attorney, if any. __________________________
____

50. Do you have any child support applications? ______ Yes ______ No
If yes, has an Order been issued by any Court? ______________________________
Do any arrearage exist? ____

51. Are you aware of any federal and/or IRS tax liens against you? _____ Yes _____ No
If yes, please explain. ____
____
____

SPOUSE INFORMATION

52. Spouse's Full Name:
(at the time of the accident): ______________________________________
Age: _____________ Date of Birth: _______________________

53. How long have you been married? ______________________________________

54. Spouse's Occupation: ____

CHILDREN

55. Do you have any Children? _______ Yes _______ No

If so, please state:

Name	Age	DOB	Living w/ you at time of accident		living w/ you now	
			Y ______	N ______	Y ____	N ____
			Y ______	N ______	Y ____	N ____
			Y ______	N ______	Y ____	N ____
			Y ______	N ______	Y ____	N ____
			Y ______	N ______	Y ____	N ____
			Y ______	N ______	Y ____	N ____

56. Have you **EVER** suffered from any **SIMILAR** pain, injury or condition at **ANYTIME PRIOR** to this accident? ______ Yes _______ No

If so, fully describe: ____

____

____

57. Have you **EVER** been treated by any of the following physicians **PRIOR** to your current accident?

Chiropractor: ______ Yes _______ No

Orthopedic Surgeon: ______ Yes _______ No

Neurologist: ______ Yes _______ No

Neurosurgeon: ______ Yes _______ No

Physical Therapist: ______ Yes _______ No

58. Prior to this accident, have you ever made a claim to be compensated for injuries?

_____ Yes ______ No

59. How were you referred to this office?

Attorney ___________________ Friend/Relative ___________________

Yellow Pages ___________________ Other ___________________

DIAGRAM