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

Confidential Client Questionnaire

PERSONAL INJURY

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)**

_____

12. Do you know if there were any witnesses to the accident?

____ Yes ____ No

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

_____

_____

_____

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

_____

_____

14. 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:

_____

_____

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

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

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

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

If so, which hospital were you taken to? _____

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

19. 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: _____

EMPLOYMENT INFORMATION

20. Name of your employer at the time of the accident: _____

Employer's Address: _____

21. How long had you worked for this employer prior to the accident? _____

22. Job title at the time of the accident: _____

23. Duties: _____

_____

_____

24. Rate of pay at the time of the accident: _____

25. 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

_____

_____

26. Did you lose any wages? _____ Yes _____ No

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

27. Have you used vacation or sick time to avoid losing wages? ____ Yes ____ No

28. 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

29. 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? _____

30. What is the claim number? _____

31. Have you spoken with anyone from the insurance company? _____ Yes _____ No

32. Did anyone take a recorded statement from you? _____ Yes _____ No

33. 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

34. 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? _____

35. 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. _____

36. Do you have any child support applications? _____ Yes _____ No

If yes, has an Order been issued by any Court? _____

Do any arrearage exist? _____

37. Are you aware of any federal and/or IRS tax liens against you? ____ Yes ____ No

If yes, please explain. _____

_____

_____

SPOUSE INFORMATION

38. Spouse's Full Name: **(at the time of the accident)**: _____

Age: _____ Date of Birth: _____

39. How long have you been married? _____

40. Spouse's Occupation: _____

CHILDREN

41. 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 ____	

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

If so, fully describe: _____

_____

_____

43. 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

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

_____ Yes _____ No

45. How were you referred to this office?

Attorney	_____	Friend/Relative	_____
Yellow Pages	_____	Other	_____