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Personal Injury (Auto Accident)

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Waldron/Tate/Land

Waldron Tate Bowen Land LLC
156 E. Market St., 5th Floor
Indianapolis, IN 46204

On behalf of Waldron Tate Bowen Land LLC, (“Firm”), thank you for giving us the opportunity to represent you. Our Firm is committed to providing top quality legal representation and services customized to each client’s needs. Please read the privacy policy below, and then fill out this form in its entirety.

Privacy Policy
All information received from a client is strictly confidential. Our firm takes every step possible to protect your privacy. The data submitted via this form is encrypted and secured using industry-standard 256-bit SSL encryption.

Your Social Security number and other personal information will only be used only when necessary in limited use during the course of your case.

Social Security numbers are most often used to positively identify parties. Most courts require Social Security numbers of all parties in a case. Some other examples of how this information may be used include:

- initial service
- in court orders
- in required reports or other documents filed with the State
- to gather medical and employment records

If you have any questions, please don't hesitate to contact our law office. We look forward to working with you!

Contact information: Name and Address

Prefix

First name *

Middle name

Last name *

Date of birth

MM/DD/YYYY

Email (required when in public form)

Phone number

Street address

City

State/Province

Zip/Postal code

Social Security Number:

Please enter your response

Does anyone else live with you at your current address?

- ◯ Yes
- ◯ No

All Addresses for last 10 years:

Please enter your response

Are you married?

- ◯ Yes
- ◯ No

Are you divorced?

- ◯ Yes
- ◯ No

Do you have children?

- ◯ Yes
- ◯ No

Have you ever gone by any other names? (e.g., maiden name)

- ◯ Yes
- ◯ No

Secondary Contact Name (Optional):

Please enter your response

Secondary Contact Phone Number (Optional):

Please enter your response

Driver's License State and Number:

Please enter your response

Have you ever filed for bankruptcy?

- ◯ Yes
- ◯ No

Collision Information

Is this an auto accident?

- ◯ Yes
- ◯ No

Where you the driver or passenger?

- ◯ Driver
- ◯ Passenger
- ◯ Other (e.g., Pedestrian)

Date of Incident

Time of Incident (also include am or pm)

Please enter your response

City of Incident

Please enter your response

County of Incident

Please enter your response

Road/Intersection (if known)

Please enter your response

Were the police called to the scene?

- ◯ Yes
- ◯ No

Was an accident or incident report filed?

- ◯ Yes
- ◯ No
- ◯ Unknown

Describe how the collision occurred:

Please enter your response

How did you car leave the scene?

- ◯ Towed
- ◯ Able to be driven away
- ◯ Other

Other Party (if known)

Name of other Party:

Please enter your response

Other Party's Address:

Please enter your response

Other Party's Insurance Company:

Please enter your response

Your Automobile Information

What is the make, model, and year of your car?

Please enter your response

What was the damage to your car?

Please enter your response

Did you have to rent a car?

- ◯ Yes
- ◯ No

How did you leave the scene of the collision?

Please enter your response

Passengers

If applicable

Passenger 1

- ◯ Fill out passenger information
- ◯ Not applicable

Passenger 2

- ◯ Fill out passenger information
- ◯ Not applicable

Passenger 3

- ◯ Fill out passenger information
- ◯ Not applicable

Passenger 4

- ◯ Fill out passenger information
- ◯ Not applicable

Witness Information

If applicable

Witness 1

- ◯ Fill out witness information
- ◯ Not applicable

Witness 2

- ◯ Fill out witness information
- ◯ Not applicable

Witness 3

- ◯ Fill out witness information
- ◯ Not applicable

Witness 4

- ◯ Fill out witness information
- ◯ Not applicable

Names of friends/family/colleagues who can testify as to your condition pre/post incident and/or saw you through recovery:

Please enter your response

Your Automobile Insurance Information

Name of Auto Insurance Carrier:

Please enter your response

Name of Policy Holder:

Please enter your response

Policy number:

Please enter your response

Did you file a claim with your insurance?

- ◯ Yes
- ◯ No

Do you have Underinsured/Uninsured Motorist Coverage?

- ◯ Yes
- ◯ No
- ◯ Unknown

Injuries

Please describe any and all aches, complaints, discomforts and disabilities, as a result of the collision, in detail.

Please enter your response

Check all symptoms you have noticed since the collision:

☐**Headache**☐**Neck pain**☐**Hands cold**☐**Loss of balance**☐**Depression**☐**Pins & needles in arms or legs**

☐**Nervousness**☐**Numbness in toes**☐**Chest pain**☐**Neck stiffness**☐**Stomach upset**☐**Fainting**☐

Light sensitivity☐Ears ringing☐Shortness of breath☐Bruising☐Dizziness☐Sleeping problems☐

Back pain☐Memory loss☐Fatigue☐Tension☐Muscle pain

Did you go to the hospital?

- ◯ Yes
- ◯ No

Did you go by ambulance?

- ◯ Yes
- ◯ No

Did they take x-rays or other imaging?

- ◯ Yes
- ◯ No

Have you seen a doctor since the date of the collision, other than at the emergency room?

- ◯ Yes
- ◯ No

Injury History

Have you had any accidents or injuries before this collision?

Injury #1:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #2:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #3:

- ◯ Fill out injury information
- ◯ Not Applicable

Injury #4:

- ◯ Fill out injury information
- ◯ Not Applicable

Additional Past Injury Information:

Please enter your response

Are you currently on any medications?

- ◯ Yes
- ◯ No

Medical Provider History

Please provide a list of all medical providers you have seen for the last 5 years. This includes chiropractors, pharmacies, primary care providers, hospitals, specialists, etc.

Name and Address of all medical providers for the last 5 years:

Please enter your response

Loss of Earnings

If you anticipate loss of earnings due to accident related injuries, please complete the following:

Were you working at the time of the collision?

- ◯ Yes
- ◯ No

Did you miss work due to your injuries?

Please enter your response

If yes, how much work?

Please enter your response

How much money did you lose due to missed work?

Please enter your response

Additional Information:

Any additional information you think would be helpful?

Please enter your response

Document Request

Please upload or email any documents that would be helpful such as:

Medical Records
Medical Bills
Insurance Correspondence
Accident Report
Police Report
Photographs
Front and Back of Driver's License
Calendar, diary, or notes related to the collision

Would you like to attach the above documents now?

- ◯ Yes
- ◯ I will send them at a later time

THANK YOU

Thank you so much for completing this intake questionnaire. This information will be extremely helpful in moving forward with your case. We will contact you soon to discuss any further questions related to your answers.

Please click the **SUBMIT** button below when you have finished answering all questions.
This is a form preview