MANGRUM & MANGRUM, LLC

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CLIENT INTAKE FORM

CLIENT INFORMATION

	PRIMARY INJURY	SPOUSE / PARENT / SECONDARY
Client Name:	.....	.....
		Role: .....
Address:	.....	.....
	.....	.....
Phones:	Home:	Home: .....
	Cell:	Cell: .....
	Work:	Work: .....
Date of Birth:	.....	.....
Place of Birth	.....	.....
Gender:	M ☐ F ☐	M ☐ F ☐
E-Mail Address:	.....	.....
	.....	.....
Employer:	.....	.....
	.....	.....

HEALTH INSURANCE [SCAN CARDS]

1. Medicare # _____ Medicaid # _____
2. Policyholder / Member:

   _____

   Company: _____ Policy # _____

   Group #: _____ ID # _____

   Website: _____ User ID: _____ Password: _____

   Group / Employer Name: _____

3. Policyholder / Member: _____

   Company: _____ Policy # _____

   Group #: _____ ID # _____

Website: _____ User ID: _____ Password: _____

Group / Employer Name: _____

INCIDENT FACTS

Location: _____ Incident Date: _____

Parties at fault:

1. Name: _____

   Address: _____

   Insurer: _____ Policy # _____

   Claim # _____ Adjuster name & # _____

2. Name: _____

   Address: _____

   Insurer: _____ Policy # _____

   Claim # _____ Adjuster name & # _____

3. Name: _____

   Address: _____

   Insurer: _____ Policy # _____

   Claim # _____ Adjuster name & # _____

ACCIDENT OR INCIDENT

Date: _____ Time: _____

City: _____ County: _____
Did you give or sign a statement? Yes ☐ No ☐

For Whom? _____ When? _____

Do you have a copy of the statement or statements? Yes ☐ No ☐

Have you been questioned by an adjuster or investigator? Yes ☐ No ☐

When? _____ Where? _____

Name of person who questioned you? _____

Was anyone else present? _____

Was a statement recorded? Yes ☐ No ☐

Did you sign any papers? Yes ☐ No ☐ Were you given a copy? Yes ☐ No ☐

What happened in the incident?

_____

Injuries:

_____

Medical Providers:

_____

PRIOR ACCIDENTS AND INJURIES

Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem. List here every such incident whether it resulted in a claim for damages or not, stating the date, place, nature of the accident and the extent of your injuries. If none, so state. (Use additional pages as necessary.)

1. Year: ___ Nature of incident:

   _____

   Extent of injury:

   _____

   Hospital: _____ Doctor: _____

Location: _____ Medical insurer: _____

Court case? Yes ☐ No ☐ Attorney:

_____

Outcome of claim / settlement:

_____

2. Year: ___ Nature of incident:

_____

Extent of injury:

_____

Hospital: _____ Doctor: _____

Location: _____ Medical insurer: _____

Court case? Yes ☐ No ☐ Attorney:

_____

Outcome of claim / settlement:

_____

3. Year: ___ Nature of incident:

_____

Extent of injury:

_____

Hospital: _____ Doctor: _____

Location: _____ Medical insurer: _____

Court case? Yes ☐ No ☐ Attorney:

_____

Outcome of claim / settlement:

_____

MEDICAL HISTORY

List here EVERY physical examination you have ever had during the last 10 years, for employment, promotion, insurance, selective service, armed forces, etc., stating the date, name of the doctor and result as fully as you can recall.

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

Date: ___ Place: _____

Doctor's name and address: _____

Purpose: ___ Result: _____

ACCIDENTS OR INJURIES AFTER THIS ACCIDENT

If you have had ANY accident or injury since the one for which we are representing you, please state as to each:

Date, time and place: _____

How it happened: _____

Was there any accident or police report? Yes ☐ No ☐ If yes, give details: _____

Were you insured? Yes ☐ No ☐ If yes, by whom? _____

Names and dates of medical treatment of hospitalizations and names and addresses of treating physicians:

_____

PLEASE COPY / SCAN AND FORWARD THE FOLLOWING TO OUR OFFICE:

1. **Driver's license**
2. **Health insurance / Medicare / Medicaid cards**
3. **Incident report**
4. **Correspondence from insurers**
5. **ER papers**
6. **Medical provider's cards**
7. **Medical bills**

NOTES: