SHEP LAW GROUP

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Meridian, ID 83646

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Attorney

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Office Administrator

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Personal Injury Intake Questionnaire

This confidential information is for our records only. Please complete fully, sign and date.

I. CLIENT INFORMATION

Name: ______________________________ Date of Birth: __________ SSN: ________________

Address: __________________________________ City: ___________ State: ____ Zip: ________

Home Phone: ______________ Cell Phone: __________________ Work Phone: ______________

Fax: ______________________ Email: ____

May we contact you at these phone numbers? ___ If not, please provide alternate telephone number(s) where you may be reached: ____

Employer Name, Address and Phone No.: ____

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II. SPOUSE'S INFORMATION (if applicable)

Are you married? ☐ Yes ☐ No If Yes, please provide the following:

Spouse's Name: _________________________________ Spouse's SSN: ________________

Employer Name, Address and Phone No.: ____

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Home Phone: ______________ Cell Phone: __________________ Work Phone: ______________

Fax: ______________________ Email: ____

III. EMERGENCY CONTACT INFORMATION

Emergency Contact: ______________________________ Relation to client: ________________

Address: ____

Phone Number(s): ____

IV. INJURED PERSON (If different from Client info above)

Name: ______________________________ Date of Birth: __________ SSN: ________________

Address: __________________________________ City: ___________ State: ____ Zip: ________

Home Phone: ______________ Cell Phone: __________________ Work Phone: ______________

Employer Name, Address and Phone No.: ____

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Relation to you: ____

V. GENERAL INFORMATION

Purpose of this appointment: ______________________________

Have you ever had another attorney represent you in this matter? ☐ YES ☐ NO

If YES, please state the name and address of the attorney: ______________________________

Was the cause of the injury investigated by law enforcement: ☐ YES ☐ NO

If YES, what law enforcement agency conducted the investigation: ______________________________

VI. ACCIDENT INFORMATION

Date of injury: ______________________________

Where did injury occur: ______________________________

How was injury sustained (i.e., motor vehicle accident, slip and fall, etc.): ______________________________

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Type of injury(ies) sustained: ______________________________

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Please describe how the injury(ies) have affected the injured person's lifestyle. For example, if the injured person was an avid golfer, how have the injuries affected that, etc. (Be as detailed as possible) ____________

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VII. INSURANCE INFORMATION

What is the name, address and policy number for the auto insurance company for the vehicle involved in the accident (if applicable)? ______________________________

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Is the injured person covered by health insurance? ☐ Yes ☐ No

Is the injured person covered by Medicaid or Medicare? ☐ Yes ☐ No

If your answer is YES, please provide a copy of the injured person's insurance card and provide the following: Name(s), address(es), telephone number(s) and policy number(s), (i.e. medical, auto, home, other) for each and every insurance carrier who has paid or will pay benefits for the injured person for treatment related to the injury: ______________________________

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Did Medicare, Medicaid or other health insurance provider pay any medical expense related to this accident? If so, please state which medical provider was paid by which insurance company and the dates of service. ______________________________

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VIII. RESPONSIBLE PARTY INFORMATION

Name and address (if known) of person who caused the injury: ______________________________

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IX. MEDICAL TREATMENT

Did you seek medical treatment? ☐ YES ☐ NO

If YES, when was medical treatment first sought? ______________________________

If NO, why was medical treatment not sought? ______________________________

Treating Physician(s) name(s), address(es) and telephone number(s): ______________________________

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X. OTHER RELEVANT INFORMATION

Please provide names of other witnesses, evidence or information that might be helpful in pursuing this claim: ____

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How did you hear about Shep Law Group: ____

Referred by: ____

Newspaper: *Television:* ___ *Radio:* ___ *Google:* ___ *Bing:* __ *Other:* ________________

NOTICE OF PAYMENT OBLIGATION

I understand that I am responsible for payment of all costs incurred and fees earned for which I am seeking counsel. I understand that I will be billed on a monthly basis and my account must be paid in full each month unless other arrangements are made. If I have more than one matter with the firm, I hereby consent and direct any payment that I make be applied to the oldest account first.

I understand that, if a retainer is required, I must pay the retainer in full before any work on my case will commence. If a retainer is paid, such retainer will be applied to my monthly bill until depleted. I further understand that once my original retainer is depleted, an additional retainer may be required of me, and that work on my case may be suspended until such time as the additional retainer is paid. I also understand that once the retainer is depleted, I am responsible to pay each bill received from RSL upon receipt.

I understand that if I do not comply with payment requirements, the handling attorney may withdraw from my case and my account may be sent to a billing/collection agency, wherein additional costs may be incurred.

Signature: ________________________________ Date: ______________________________

For Official SLG Use Only:

Handling Attorney:	Opposing Counsel:
Matter Number:	Retainer Received: ( ) Y ( ) N
Matter Description:	Retainer Amount Quoted:
Billing Type (Circle One): Hourly Flat Fee Contingency	Retainer Received: ( ) Y ( ) N
Payment Arrangements:	