

# THE HARVIN LAW FIRM

A PROFESSIONAL LAW CORPORATION

**JOSEPH B. HARVIN**  
Attorney at Law  
J.D., LL.M. - Admiralty

**(985) 781-8885**  
jbharvin@harvinlawfirm.com  
Fax (985) 781-8825

Bank of Louisiana Bldg.  
636 Gause Blvd., # 303  
Slidell, LA 70458

MARITIME \* PERSONAL INJURY \* AUTO \* SUCCESSIONS \* FAMILY LAW \* NOTARY  
LOUISIANA FAMILY MEDIATOR

## INFORMATION SHEET ON PERSONAL INJURY CLAIMS

DATE OF ACCIDENT: \_\_\_\_\_ LOCATION: \_\_\_\_\_

POLICE DEPT: \_\_\_\_\_ ITEM #: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #S: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

CELL: \_\_\_\_\_ EMAIL: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ STATE: \_\_\_\_\_

EMERGENCY CONTACT (RELATIONSHIP, ADDRESS & PHONE #) \_\_\_\_\_

PARISH OF RESIDENCE: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

CHILDREN (NAMES, AGES) \_\_\_\_\_

ARE ANY OF YOUR CHILDREN DEPENDANT ON YOU FOR SUPPORT, OR LIVE WITH YOU, EVEN IF THEY ARE OVER THE AGE OF 18? \_\_\_\_\_ IF YES, NAMES AND AGES: \_\_\_\_\_

ARE ANY OF YOUR CHILDREN PHYSICALLY OR MENTALLY HANDICAPPED? \_\_\_\_\_  
IF YES, THEIR NAMES, AGES & DESCRIPTION OF HANDICAP: \_\_\_\_\_

DO YOU PROVIDE THE SUPPORT FOR EITHER OF YOUR PARENTS, OR DO YOUR PARENTS LIVE WITH YOU? \_\_\_\_\_  
IF SO, THEIR NAMES & DETAILS: \_\_\_\_\_

DO YOU LIVE WITH YOUR PARENTS, OR ARE YOU DEPENDANT ON YOUR PARENTS FOR YOUR SUPPORT? \_\_\_\_\_ IF SO, THEIR NAMES & DETAILS: \_\_\_\_\_

**ACCIDENT INFORMATION**

DATE OF ACCIDENT: \_\_\_\_\_

PLACE OF ACCIDENT: \_\_\_\_\_

TYPE OF ACCIDENT (COMPLETE DETAILS): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(USE BACK OF THESE PAGES IF NEEDED)

LIST OF OCCUPANTS IN YOUR VEHICLE: \_\_\_\_\_

WERE YOU WEARING A SEATBELT? \_\_\_\_\_

NAMES & ADDRESSES OF WITNESSES: \_\_\_\_\_  
\_\_\_\_\_

ARE THERE ANY PHOTOGRAPHS OF ACCIDENT SCENE? \_\_\_\_\_ IF SO, IN WHOSE POSSESSION? \_\_\_\_\_

DID THE CITY POLICE OR STATE POLICE INVESTIGATE? \_\_\_\_\_

WAS OTHER DRIVER DRINKING? \_\_\_\_\_

TRAFFIC VIOLATION ISSUED: \_\_\_\_\_

OBTAINED COPY OF TICKET? \_\_\_\_\_

ADVERSE PARTY: \_\_\_\_\_

ADVERSE PARTY ADDRESS: \_\_\_\_\_

TYPE/COLOR OF VEHICLE: \_\_\_\_\_

ANY OTHER INFO: \_\_\_\_\_

ADDITIONAL ADVERSE PARTIES: \_\_\_\_\_  
\_\_\_\_\_

ADVERSE PARTIES INSURANCE COMPANIES: \_\_\_\_\_  
\_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

CLAIM NO: \_\_\_\_\_ ADJUSTER: \_\_\_\_\_

WAS THERE PROPERTY DAMAGE? \_\_\_\_\_

\_\_\_\_\_ YOUR VEHICLE DEGREE: \_\_\_\_\_ LOCATION: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ OTHER VEHICLE DEGREE: \_\_\_\_\_ LOCATION: \_\_\_\_\_

\_\_\_\_\_  
DID YOU OWN THE PROPERTY? \_\_\_\_\_

IS THERE A LIENHOLDER? \_\_\_\_\_ IF SO, WHO? \_\_\_\_\_

DO YOU HAVE PHOTOGRAPHS OF THE PROPERTY DAMAGE? \_\_\_\_\_

\_\_\_\_ ACCIDENT SCENE \_\_\_\_ OTHER DRIVER/VEHICLE

WAS THERE A PRODUCT INVOLVED? \_\_\_\_\_

IF SO, WHAT WAS THE PRODUCT, DATE OF MANUFACTURE & MANUFACTURER:

\_\_\_\_\_  
\_\_\_\_\_

### **EMPLOYMENT INFORMATION**

EMPLOYER NAME & ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

NAME OF SUPERVISOR: \_\_\_\_\_

JOB DUTIES: \_\_\_\_\_

DATE BEGAN EMPLOYMENT: \_\_\_\_\_

DATE ENDED EMPLOYMENT: \_\_\_\_\_

WAGES: \_\_\_\_\_

DAYS LOST BECAUSE OF ACCIDENT: \_\_\_\_\_

WERE YOU IN THE COURSE AND SCOPE OF YOUR EMPLOYMENT AT THE TIME OF  
THE ACCIDENT? \_\_\_\_\_

**MEDICAL TREATMENT**

INJURIES SUSTAINED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WERE THERE ANY HEAD INJURIES: ? \_\_\_\_\_

ARE THERE ANY SCARS? \_\_\_\_\_

DO YOU HAVE PHOTOGRAPHS OF INJURIES? \_\_\_\_\_

PHYSICIANS: \_\_\_\_\_

\_\_\_\_\_

HOSPITALS: \_\_\_\_\_

\_\_\_\_\_

AMBULANCE: \_\_\_\_\_

ANY TESTS PERFORMED? \_\_\_\_\_ IF SO, WHAT TYPE? \_\_\_\_\_

\_\_\_\_\_

DESCRIBE ANY PRIOR OR SUBSEQUENT ACCIDENTS OR INJURIES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD THE SAME TYPE OF INJURY AS YOU SUFFERED IN THIS ACCIDENT BEFORE? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD THE SAME TYPE OF INJURY IN ANY SUBSEQUENT ACCIDENTS?

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**INSURANCE INFORMATION**

**IMPORTANT!!!!**

**BECAUSE OF “NO PAY/NO PLAY” INSURANCE LAW,  
WE MUST HAVE PROOF OF INSURANCE FROM OUR CLIENTS  
AS THE FIRST \$10,000 IN DAMAGES CAN BE AFFECTED.**

IS THERE MINIMUM LIABILITY INSURANCE COVERAGE AS REQUIRED BY LAW  
(15/25/30) ON YOUR PERSONAL VEHICLE AND/OR THE VEHICLE WHICH YOU WERE  
OCCUPYING AT THE TIME OF THIS ACCIDENT? \_\_\_\_\_  
(Copy Proof of Insurance Card for File)

DO YOU HAVE UNINSURED/UNDERINSURED MOTORISTS INSURANCE:? \_\_\_\_\_

DO YOU HAVE MEDICAL PAYMENTS COVERAGE? \_\_\_\_\_

ALL HEALTH INSURANCE OF ANY KIND WHICH YOU HAVE: \_\_\_\_\_

ALL DISABILITY (INCLUDING CREDIT LIFE) INSURANCE YOU HAVE: \_\_\_\_\_

HAVE YOU APPLIED FOR SOCIAL SECURITY BENEFITS? \_\_\_\_\_

ARE YOU ALREADY RECEIVING SS BENEFITS? \_\_\_\_\_ IF SO, WHY? \_\_\_\_\_

DO YOU HAVE A MEDICAID OR MEDICARE CARD? \_\_\_\_\_

MEDICAID # \_\_\_\_\_ MEDICARE # \_\_\_\_\_

HAVE YOU USED IT FOR MEDICAL CARE ON THIS ACCIDENT? \_\_\_\_\_

DO YOU HAVE MEDICARE SECONDARY MEDICAL PROVIDER INSURANCE AND IF

SO NAME, POLICY NUMBER, CONTACT INFO? \_\_\_\_\_  
\_\_\_\_\_

**MISCELLANEOUS INFORMATION**

DO YOU READ & WRITE? \_\_\_\_\_ LEVEL OF EDUCATION: \_\_\_\_\_

WERE YOU REFERRED TO THIS LAW FIRM BY ANYONE? \_\_\_\_\_  
IF SO, BY WHOM? \_\_\_\_\_

IF NOT, HOW DID YOU CHOSE THIS LAW FIRM? \_\_\_\_\_

\_\_\_\_\_  
HAVE YOU SEEN ANOTHER ATTORNEY IN CONNECTION WITH THIS CASE? \_\_\_\_\_

IF SO, WHOM? \_\_\_\_\_

HAVE YOU SIGNED ANY CONTRACTS WITH THAT ATTORNEY? \_\_\_\_\_

HAVE YOU EVER BEEN ARRESTED? \_\_\_\_\_

HAVE YOU EVER BEEN CONVICTED OF ANY OFFENSE? \_\_\_\_\_ IF YES, PLEASE  
GIVE DETAILS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**I ACKNOWLEDGE THAT I HAVE SUPPLIED THE INFORMATION CONTAINED  
IN THIS INTAKE FORM, THAT THE INFORMATION PROVIDED IS TRUE AND  
CORRECT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF AND  
IS BEING PROVIDED TO MY ATTORNEYS REGARDING MY CLAIM. I FURTHER  
ACKNOWLEDGE THAT I HAVE BEEN ADVISED THAT THE ABOVE INFORMATION  
IS NORMALLY REQUESTED AND DISCOVERABLE IN PERSONAL INJURY CLAIMS.**

\_\_\_\_\_  
SIGNATURE OF INTERVIEWER

\_\_\_\_\_  
SIGNATURE OF CLIENT