

Personal Injury /Auto Accident or Slip & Fall Case

- ◆ Do you have No - Fault P. I. P. benefits? YES: NO:
- ◆ Are there benefits left? YES: NO:
- ◆ Do you have a deductible? YES: NO:
- ◆ Deductible amount? \$ _____ Has it been met yet? YES: NO:
- ◆ If not, how much deductible is left to be met yet \$ _____
- ◆ What percentage does your insurance cover _____ %
- ◆ What are the policy limits \$ _____
- ◆ Do you have MED-PAY on your policy? YES: NO: (picks up the .20%)
- ◆ Do you have U/M (Uninsured Motorist Protection)? YES: NO:
- ◆ Were you cited in the accident? YES: NO: Don't know:
- ◆ Were you struck from: Behind: Front: R. Side: L. Side:
- ◆ If other, please explain: _____
- ◆ Did you feel pain immediately? YES: NO: If Yes, Where _____
- ◆ If NO, when did you first start feeling pain? _____
- ◆ Since the injury are your symptoms: Getting worse: Improving:
- ◆ Staying the same Changing (If changing, explain): _____

- ◆ Were You the: Driver Passenger Pedestrian Other _____
- ◆ Have you received massage therapy for this medical condition? Yes or No
- ◆ Have you received massage therapy for any medical condition in the past? Yes No
If YES, did it help? Yes No
- ◆ If you live in a state that is not a no-fault state or do not have MED-PAY on your policy, you must supply the following information.

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name: _____ Phone #: _____

Address: _____ Policy #: _____

Have you obtained an attorney for this case YES: NO: IF YES, Please fill out our **Attorney Letter of Protection** and provide your attorney's name, phone and fax numbers.