NEW CLIENT REPORT/WORKSHEET (PERSONAL INJURY)
LAW OFFICE OF GLEN EDWARD ASHMAN

Date of Accident:_____ Interview Date:_____ Limitation Date: _____
Attorney fills this in Attorney fills this in

CLIENT INFORMATION:

Last:_____ First:_____ M.I._____

DOB: (___/___/____) SSN: _____ - _____ - _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse:

Last:_____ First:_____ DOB: (___/___/____) SSN: _____ - _____ - _____

If married, was spouse involved in this accident? Yes_____ No _____

Minor Child involved in this accident:
Last:_____ First:_____ DOB: (___/___/____) SSN: _____ - _____ - _____
Last:_____ First:_____ DOB: (___/___/____) SSN: _____ - _____ - _____
Last:_____ First:_____ DOB: (___/___/____) SSN: _____ - _____ - _____
Last:_____ First:_____ DOB: (___/___/____) SSN: _____ - _____ - _____

Phone Numbers:

Home:_____ Work:_____ Cell:_____

Email: _____

Mailing Address:

_____ _____ _____
Street Address & Apartment No. City State Zip

Nearest Contact:_____ Phone No:_____
(this person WILL BE contacted in the event we cannot reach you)

Are you currently in or planning to file a bankruptcy? Yes ___ No ___ If yes, which chapter 7 or 13? ____

ACCIDENT INFORMATION:

Date of Accident:_____ City/Responding Police Dept: _____ Accident Report Number: _____

Were you transported BY AMBULANCE to the hospital? Yes___No___

If yes, which ambulance service? _____

Were you transported by car to the hospital? Yes ___ No ___

What hospital did you go to? _____

Were you Hospitalized? Yes_____ No_____ If yes, how long were you hospitalized? _____

Were X-Rays taken at the hospital? Yes____No____

Were you on the Job at Time of Accident? Yes_____ No____

Government Vehicle? Yes____ No____ How many were in your vehicle?_____

No. of Vehicles Involved:_____

Were you the driver? Yes____ No____

List ALL persons in the vehicle at the time of the accident other than yourself:

1) _____ 3) _____

2) _____ 4) _____

Did you have lost wages? Yes____ No_____

Previous Accidents (give dates):_____

MEDICAL TREATMENT:

List ALL Doctors, Hospitals, Chiropractors, Therapists seen as a result of this accident:

1) _____ 4) _____

_____ _____

2) _____ 5) _____

_____ _____

3) _____ 6) _____

_____ _____

What type of injuries did you sustain as a result of this accident? BE SPECIFIC

_____

HEALTH INSURANCE, MEDICARE, MEDICAID, CHAMPUS, ETC:

Do you have any private health care insurance? Yes ☐ No ☐

If yes, who is your carrier?_____

Do you have Medicaid or Medicare? Yes ☐ No ☐ ID Number: _____

Do you have Med Pay benefits on your current auto insurance policy? ☐ Yes ☐ No

If yes, how much? _____

FAULT AND PROPERTY DAMAGE:

	AT FAULT VEHICLE	CLIENT VEHICLE
Insurance Company	_____	_____
Address	_____	_____
City, State, Zip	_____	_____
Policy No.	_____	_____
Claim No.	_____	_____
Adjuster	_____	_____
Phone No.	_____	_____
Driver	_____	_____
Insured	_____	_____

At-Fault Driver

Citation: Yes _____ No_____

Contributing Factors:

_____

_____

_____

Court Date:_____ Time:_____

Client

Citation: Yes _____ No _____

Contributing Factors:

_____

_____

_____

Property Estimate: $_____

Damage:_____

_____

Attorney Glen Ashman is located at 2791 Main Street, East Point GA 30344. On many accident matters he works with Attorney Joel Baskin as co-counsel. Please let us know which office is more convenient for you:

☐ Glen E. Ashman Law Office 404-768-3509
2791 Main Street
East Point, Georgia 30344

☐ Joel M. Baskin, PC Law Office
2675 Paces Ferry Road, Suite 220
Atlanta, Georgia 30339

WHEN THIS WORKSHEET IS COMPLETE, PLEASE SET AN APPOINTMENT WITH ATTORNEY ASHMAN. IF YOU HAVE THEM, BRING THE POLICE ACCIDENT REPORT, ANY MEDICAL PAPERWORK/BILLS, CAR REPAIR ESTIMATES AND PHOTOS. PHOTOS HELP A LOT - GET PHOTOS OF THE CARS, ACCIDENT LOCATION AND INJURIES IF POSSIBLE.