

**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

Client

Citation: Yes _____ No _____

Citation: Yes _____ No _____

Contributing Factors:

Contributing Factors:

Court Date: _____ Time: _____

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.