NEW CASE INTAKE SHEET
THE LAW OFFICE OF RICK J. LASHER, PLLC
27 Phipps Lane
Plainview, NY 11803

CLIENT INFORMATION:

Name: _____ Date Retained: _____

Address: _____

Phone (Home): _____ Phone (Cell): _____

Phone (Work): _____ Other Phone No.: _____

Email: _____

Referred By: Name: _____
Phone No.: _____
Address of Referrer: _____

Date of Birth: _____ SS#: _____

Languages: _____

Marital Status: [ ] Married [ ] Single/Divorced [ ] Partner

Spouse Name: _____
Date of Marriage: _____

Member(s) of Household (Name & DOB): _____

Highest Level of Education & Where: _____

ACCIDENT INFORMATION

Type of Accident: [ ] Auto [ ] Slip & Fall [ ] Products

[ ] Trip & Fall [ ] Med Mal [ ] Other _____

Date of Accident: _____ Time: _____

Location of Accident: _____

Owner of Property (if S&F or T&F): _____

Workers' Comp? [ ] Yes [ ] No
If Yes, W/C Atty: _____

Description of Accident: (diagram if confusing)

Police or Incident Report? [ ] Yes [ ] No
If no, Explain: _____

Witnesses: (Name Address, Phone #)

_____

Did you speak with Defendant? (If MVA)

_____

Did you speak to police?

_____

Did Defendant speak to police?

_____

Anything else we should know?

_____

INSURANCE INFORMATION: (Obtain copy of insurance card where applicable.)

No-Fault/Workers' Comp Carrier:

Name of Company: _____
Policy Number: _____
Insured: _____
Claim Number: _____
Adjuster: _____ Phone No.: _____

Liability Carrier:

Name of Company: _____
Policy Number: _____
Insured: _____
Claim Number: _____
Adjuster: _____ Phone No.: _____

Household Carrier [ ] Yes [ ] No

Name of Company: _____
Policy Number: _____
Insured: _____

Primary and Secondary Health Insurance Info:

Name of Company: _____
Policy Number: _____
Insured: _____

Are you now or have ever been enrolled in Medicare Part A or Part B?
[ ] Yes [ ] No

INJURY INFORMATION:

Initial Complaints:

At the time of the accident:
Parts of body: _____
Any Bleedings: _____
Any Bruises: _____
Pain: _____
Swelling: _____

Other: _____

Currently:

Parts of body: _____
Any Bleedings: _____
Any Bruises: _____
Pain: _____
Swelling: _____
Other: _____

Prior/Current Medical Conditions: (i.e., diabetes, high blood pressure, pregnancy)

PRIOR ACCIDENT OR INJURIES:

Date of Accident	Type of Accident	Claim(s) Filed	Injuries

As to this Accident

Hospital: [ ] Yes [ ] No

Name of Hospital: _____
Date of Visit: _____
Treatment: _____

All Doctors:

Name of Hospital: _____
Address: _____
Phone No.: _____
Date of Initial Visit: _____

Name of Hospital: _____
Address: _____
Phone No.: _____
Date of Initial Visit: _____

EMPLOYEMENT

Name of Employer: _____
Address: _____
Phone No.: _____ Salary: _____
Position: _____

Time Out: _____

IF PROPERTY DAMAGE:

Year: _____ Make: _____
Owner:_____ Type of Coverage: _____
Amt of Damage:_____ Amt Paid: _____
Paid By: _____ % Paid: _____