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**Automobile Accident Intake Sheet**

**Date:** \_\_\_\_\_

**File No.:** \_\_\_\_\_

**Referral Source:** \_\_\_\_\_

**Client Interviewed By:** \_\_\_\_\_

**City/Public Authority Involved? Yes[  ] No[  ]**

**If Yes: State Authority:**

\_\_\_\_\_

**Critical Deadlines:** \_\_\_\_\_

**NOC Deadline:** \_\_\_\_\_

**SOL:** \_\_\_\_\_

**I. BACKGROUND INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Date of Birth: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Marital status: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

Spouse's Age: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Phone Nos.: Home: \_\_\_\_\_ Business: \_\_\_\_\_

Cell: \_\_\_\_\_ Other: \_\_\_\_\_

Email: \_\_\_\_\_

**II. EMPLOYMENT BACKGROUND**

Employer: \_\_\_\_\_

Work address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

What is your present job title? \_\_\_\_\_

What are your job duties? (Be specific and complete.)

\_\_\_\_\_

What is your rate of pay? \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

Were you employed at the time of the accident/incident? \_\_\_\_\_

Did the accident occur while you were working for your employer?

Yes : \_\_\_\_\_ No: \_\_\_\_\_

**Did the accident occur while you were at the workplace?**

**Yes :** \_\_\_\_\_ **No:** \_\_\_\_\_

**III. AUTOMOBILE ACCIDENT INTAKE SHEET**

**Day:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_ **Weather:** \_\_\_\_\_

**Please Describe the  
accident:** \_\_\_\_\_

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**Precinct:** \_\_\_\_\_ **Accident No.:** \_\_\_\_\_

**Do you have a copy of the police report?**

**Yes :** \_\_\_\_\_ **No:** \_\_\_\_\_

If yes, please attach a copy

**IV. MEDICAL CARE**

Emergency Care at Scene? Yes: [    ]      No: [    ]

Ambulance: Yes [    ]      No [    ]

Hospital: \_\_\_\_\_

\_\_\_\_\_

Address	City	Zip
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Phone Number: \_\_\_\_\_

Date Of Treatment: \_\_\_\_\_

Date Of Discharge: \_\_\_\_\_

Treatment Type:    ER [    ]      Admission [    ]

Outpatient [    ]      Clinic Visit [    ]

**List the name, address, and telephone number of each physician, psychiatrist or other medical care provider who has examined, treated or interviewed you relating to your current injuries, and for each one complete the following:**

(a)    Physician's name \_\_\_\_\_

\_\_\_\_\_

Address	City	Zip
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Telephone number \_\_\_\_\_

Date of treatment \_\_\_\_\_

Treatment prescribed \_\_\_\_\_

Costs incurred \_\_\_\_\_

(b) **Physician's name** \_\_\_\_\_

\_\_\_\_\_  
**Address** **City** **Zip**

**Telephone number** \_\_\_\_\_

**Date of treatment** \_\_\_\_\_

**Treatment prescribed** \_\_\_\_\_

**Costs incurred** \_\_\_\_\_

(c) **Physician's name** \_\_\_\_\_

\_\_\_\_\_  
**Address** **City** **Zip**

**Telephone number** \_\_\_\_\_

**Date of treatment** \_\_\_\_\_

**Treatment prescribed** \_\_\_\_\_

**Costs incurred** \_\_\_\_\_

**Notes:**

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