



# CRAIN | SCHUETTE ATTORNEYS

Larry L. Crain (TN, VA, DC)  
Brian Schuette (KY, TN)  
C. David Keen (KY)  
James C. Jones, (KY)  
C. Michael Carey (KY)  
Amanda Blakeman (KY)  
Joshua D. Hershberger (KY, IN)  
Ashlea Shepherd Porter (KY)

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## VITAL INFORMATION

### CLIENT:

|   |                                |
|---|--------------------------------|
| _____<br>Name (and name of child if applicable) | _____<br>Place of employment   |
| _____<br>Street address or Post Office Box      | _____<br>Employer Address      |
| _____<br>City, State, Zip Code                  | _____<br>City, State, Zip Code |
| _____<br>Telephone Number(s)                    | _____<br>Telephone Number(s)   |
| _____<br>Email Address                          | _____<br>Date of Birth         |
| _____<br>Social Security Number                 | _____<br>Name of Spouse        |
| _____<br>Driver, Passenger, Pedestrian          |                                |

### ACCIDENT:

|                               |                                |
|-------------------------------|--------------------------------|
| _____<br>Date of Accident     | _____<br>Adverse Driver        |
| _____<br>City and County      | _____<br>Address               |
| _____<br>Investigating Agency | _____<br>City, State, Zip Code |

INSURANCE COMPANIES

COMPANY #1

COMPANY #2

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Type of coverage (PIP, Liability, etc)

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Type of coverage (PIP, Liability, etc)

---

Name of Company

---

Name of Company

---

Address

---

Address

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City, State, Zip Code

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City, State, Zip Code

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Telephone Number(s)

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Telephone Number(s)

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Adjuster

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Adjuster

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Claim Number

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Claim Number

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Named Insured

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Named Insured

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Additional Insured

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Additional Insured

ADDITIONAL INSURANCE COMPANIES

COMPANY # \_\_\_\_\_

COMPANY # \_\_\_\_\_

\_\_\_\_\_  
Type of coverage (PIP, Liability, etc)

\_\_\_\_\_  
Type of coverage (PIP, Liability, etc)

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Name of Company

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Telephone Number(s)

\_\_\_\_\_  
Adjuster

\_\_\_\_\_  
Adjuster

\_\_\_\_\_  
Claim Number

\_\_\_\_\_  
Claim Number

\_\_\_\_\_  
Named Insured

\_\_\_\_\_  
Named Insured

\_\_\_\_\_  
Additional Insured

\_\_\_\_\_  
Additional Insured

MEDICAL PROVIDERS

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Phone Number  
\_\_\_\_\_  
Dates of Treatment \_\_\_\_\_  
\_\_\_\_\_  
Account # \_\_\_\_\_  
\_\_\_\_\_  
Records Ordered \_\_\_\_\_  
\_\_\_\_\_  
Records Received \_\_\_\_\_

\_\_\_\_\_  
Name  
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Address  
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City, State, Zip Code  
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Phone Number  
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Dates of Treatment \_\_\_\_\_  
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Account # \_\_\_\_\_  
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Records Ordered \_\_\_\_\_  
\_\_\_\_\_  
Records Received \_\_\_\_\_

SUMMARY OF ACCIDENT FACTS

SUMMARY OF INJURIES

CHRONOLOGY OF TREATMENT

PRIOR MEDICAL HISTORY AND/OR INJURIES