

Colacci Law Firm, L.L.C.

Client Information

DATE OF ACCIDENT: _____ FILE NO: _____ ATTY: _____

Plaintiff Name _____ M: ____ F: ____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

DOB _____ SSN _____

Email _____

Occupation _____

Employer Address _____

Representative

Name _____

Address _____

City _____ State _____ ZIP _____

Relationship to Plaintiff _____

Family

Spouse _____ DOB _____ SSN _____

Employer _____ Work Phone _____

Children _____ DOB _____

Address _____

Children _____ DOB _____

Address _____

Name of Person Writing Up Case _____ Date _____

How Did Client Hear About Colacci Law?

Radio

☐ 101.5 WKXW
☐ 105.7 HAWK
☐ 1450 WCTC
☐ 98.3 WMGQ

Television

<input type="checkbox"/> Cablevision Raritan	<input type="checkbox"/> Cablevision Monmouth
<input type="checkbox"/> Comcast Union – South	<input type="checkbox"/> Comcast Monmouth
<input type="checkbox"/> Comcast Middlesex	<input type="checkbox"/> Comcast Ocean South (Toms River)
<input type="checkbox"/> Comcast Princeton	<input type="checkbox"/> Comcast Ocean North (Brick)
	<input type="checkbox"/> Jerry Springer Show (WPIX – Ch. 11)

Phone Book

<input type="checkbox"/> Verizon (Ideae)	County _____
<input type="checkbox"/> Sprint (Embark)	County _____
<input type="checkbox"/> Yellow Book	County _____
<input type="checkbox"/> Other	County _____

Internet

Website _____

Newspaper

<input type="checkbox"/> Asbury Park Press	<input type="checkbox"/> Home News Tribune	
<input type="checkbox"/> Star Ledger	<input type="checkbox"/> Hunterdon County Democrat	<input type="checkbox"/> Other

Sign

Edison ☐ Flemington ☐ Belford ☐ Howell ☐ Somerville ☐ Jamesburg ☐ Forked River ☐

Other

<input type="checkbox"/> Prior Client	Name _____
<input type="checkbox"/> Referred by Former or Current Client	Name _____
<input type="checkbox"/> Referred by an Associate	Name _____
<input type="checkbox"/> Referred by a Partner	Name _____
<input type="checkbox"/> Referred by Outside Attorney	Name _____
<input type="checkbox"/> Referred by Friend of Office	Name _____
<input type="checkbox"/> Other	Name _____
<input type="checkbox"/> Direct Mail	
<input type="checkbox"/> Newsletter, Email	
<input type="checkbox"/> Unknown	

Type of Case

- | | |
|------------------------|---------------------------------|
| 1. Auto | 11. Other Occupational Diseases |
| 2. Fall Down | 12. Drugs, Etc. |
| 3. Products | 13. Dog Bite |
| 4. Construction | 14. Uninsured Motorist |
| 5. Medical Malpractice | 15. PIP |
| 6. Legal Malpractice | 16. Nursing Home Malpractice |
| 7. Other Malpractice | 17. Workers' Compensation |
| 8. Machine | 18. Social Security |
| 9. Swimming or Sports | 19. Miscellaneous |
| 10. Asbestos | 20. Dram Shop |

Liability

Excellent ____ Good ____ Fair ____ Poor ____ Cannot Determine ____

Estimated Value

0-10,000 ____ 10-25,000 ____ 25-50,000 ____ 50-100,000 ____ 100,000+ ____

Defendants

Δ1 Name _____

Address _____

City _____ State _____ ZIP _____

Carrier _____

Δ 2 Name _____

Address _____

City _____ State _____ ZIP _____

Carrier _____

Δ 3 Name _____

Address _____

City _____ State _____ ZIP _____

Carrier _____

Accident Information

Accident Facts

Witnesses

Name _____ Address _____

Name _____ Address _____

Site of the Accident

Street _____ Town _____ City _____

Conditions at the Site

Weather/Road/Floor _____

Police Report ____

Photos of Auto ____

Incident Report ____

Photos of Location/Defect ____

Accident Reported ____

To Whom _____ By Whom _____

Recorded Statement ____

Prior Accidents/Injuries?

Prior MRIs/Testing?

Prior Lawsuits?

Workers' Compensation Claims?

Bankruptcy?

Medical Information

Injuries

Physicians

Dr. 1 Name _____

Address _____

City _____ State _____ ZIP _____

Referred by _____

Dr. 2 Name _____

Address _____

City _____ State _____ ZIP _____

Referred by _____

Hospital _____ Date _____

Ambulance ____ Backboard ____ Cervical Collar ____

Family Physician

Family Physician Name _____

Address _____

City _____ State _____ ZIP _____

Chiropractor

Chiropractor Name _____

Address _____

City _____ State _____ ZIP _____

Wage Loss

Lost Time to Date _____

Primary Employer _____

Earnings _____ Overtime _____

Secondary Employer _____

Earnings _____ Overtime _____

Insurance Information

PIP

Carrier _____ Policy Number _____

Deductable _____ Tort Threshold _____

Additional Auto Policies *(List All Members in Household -- Auto Cases ONLY)*

Name _____ Relationship _____ Auto Carrier _____

Name _____ Relationship _____ Auto Carrier _____

Name _____ Relationship _____ Auto Carrier _____

Name _____ Relationship _____ Auto Carrier _____

Health *(Photocopy Health Card)*

Carrier _____ Policy Number _____

Workers' Compensation

Carrier _____ Policy Number _____

Other Liens

Welfare _____ Medicare _____

Medicaid _____ Physicians _____

Disability Insurance _____

Major Medical Insurance _____

Internet *(What do you have posted anywhere on the internet?)*

Client Reminders

- Warn every client that he/she may be the subject of a video surveillance
- Warn every auto client of PIP statute of limitations
- Warn every client regarding discussing case & contact from insurer/adjuster/investigator
- Remind every client we need to be provided with complete treatment & doctor history
- Remind every client to keep apprised of status changes (e.g. health, treatment, address)