Deborah L. Barron
Barrister & Solicitor

Accident Interview Form

Today's Date:_____

Date of Accident:_____ **201**___ **Time of Accident:** _____**am / pm**

Referred By (eg: Google, friend, doctor): _____

Client:_____

Address:_____

_____**Postal Code**_____

Date of Birth:_____**Age:**_____

Phone: (H)_____**(W)**_____ **Email:** _____

Marital status: _____ **Name of spouse**:_____

Do you have child(ren)?_____ **Child(ren)'s name(s) and birthdates**: _____

_____

NOTES TO CLIENT

1) PLEASE DO NOT TALK TO WRONGDOER'S ADJUSTER (who is looking for information only to help the wrongdoer) – INSTEAD, PLEASE JUST OBTAIN THE ADJUSTER'S NAME, COMPANY NAME, PHONE NUMBERS, CLAIM NUMBER and provide Deborah with this information.

2) YOU MAY BE UNDER SURVEILLANCE – NOTIFY US IF YOU OBSERVE THIS, TO DISCUSS.

Macleod Place II, 5th Floor, 5940 Macleod Trail S.W., Calgary, Alberta T2H 2G4
ph. 403.238.0000 email dbarron@deborahbarronlaw.com

YOUR MOTOR VEHICLE INSURANCE COMPANY (your insurer)
(if you were a passenger, this is your driver's insurance company)

Name of your insurer (eg. Intact): _____

Name of individual adjuster at your insurer:_____

Adjuster's phone number/email/fax number: _____

Your policy number and claim number:_____

YOUR MOTOR VEHICLE
(if you were a passenger, this is your driver's motor vehicle)

Year, make, model and color: _____

Name of registered owner:_____

Dollar value of damage sustained in accident (also, please attach estimate/repair documents, if available): $_____

Occupants of your vehicle at the time of the accident:_____

WRONGDOER'S MOTOR VEHICLE

Year, Make, Model and Color of wrongdoer's motor vehicle: _____

License Plate #:_____

Motor vehicle VIN #:_____

Describe damage to wrongdoer's vehicle:_____

THE WRONGDOER'S MOTOR VEHICLE INSURANCE COMPANY

Name of the wrongdoer's insurance company (eg. Intact): _____

Name of adjuster at wrongdoer's insurance company:_____

Wrongdoer's insurance adjuster's phone number/email/fax number:
_____

Wrongdoer's insurance adjuster's claim number:_____

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WRONGDOER DETAILS

If you have photographed the wrongdoer's driver's license and vehicle insurance card, please email Deborah the photographs. If you have a copy of the police Collision Report Form, please email that to Deborah. Additionally, please fill in the following details about the wrongdoer that you have written down at the accident scene:

Name of the wrongdoer driver: _____

Address of wrongdoer driver:_____

Telephone number:_____

Name of owner of the wrongdoer's vehicle: _____

Address of owner of wrongdoer's vehicle:_____

Telephone number:_____

Relationship of owner and driver, if you are aware of this:

eg. Married couple, father/daughter, business/employee: _____

Wrongdoer driver's Driver License number: _____

Insurance Card:
Name of wrongdoer's insurance company and adjuster _____

Policy number _____

Names, addresses and telephone numbers of witnesses:

_____

_____

SCENE OF ACCIDENT

Location:_____

Weather:_____**Weather:**_____**Street Lights: Yes / No**

Type and Condition of Road_____

Hill, curve, bridge, etc.:_____

Traffic Lights or Signs_____

Marked Traffic Lanes:_____

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Any Charges Laid:_____**Result:**_____

List any medications, alcohol or drugs taken by you within 24 hours of the accident (this is confidential):
_____

EVIDENCE

Any admission made or statements signed:_____

Names / Phone Numbers of Witnesses_____

_____

DESCRIPTION OF ACCIDENT

_____

_____

INJURIES

Nature of Injuries:_____

_____

_____

Were you examined by paramedics at the accident scene?_____

Were you transported to hospital by ambulance from the accident scene?_____

Hospitalized: Yes / No If yes, which hospital and what dates:_____

_____

Please list and describe all prior vehicle related accidents and injuries sustained, if any:
_____

Please list all prior accidents and injuries sustained from sports, activities, falls, etc., if any:
_____

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NAME / FACILITY OF TREATING PRACTITIONERS

Attending Physician:_____

Family Physician:_____

Chiropractor:_____

Physiotherapist:_____

Massage Therapy:_____

Other / Specialists:_____

Other / Specialists: _____

Restriction of Activities:_____

_____

Previous Health and Physical Condition:_____

Previous Injuries:_____

EMPLOYMENT / WAGE LOSS INFORMATION

Will you be advancing a wage loss claim? Yes / No / Don't Know Yet

Employer:_____

Address:_____

Fax: _____**Phone:**_____**Postal Code**_____

Job Title:_____ **Length of time at this job**:_____

Dates Absent from Work:_____

Wages / Salary:_____**Full or Part-time:**_____

Employment Benefits:_____

Benefit Details: Group Plan No.:_____**I.D No.:**_____

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SPECIAL DAMAGES (PLEASE FORWARD SUBSTANTIATING RECEIPTS & INVOICES)

Loss of Income or Opportunity to Work_____

Clothing and Personal Articles:_____

Household Help:_____

Taxi / Train / Bus Fares:_____

Out of Pocket Expenses: (i.e. prescriptions, over the counter medications)_____

_____

Other:_____

_____

Please provide: Personal Health Number: _____

Private Health Insurance: _____

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