



WWW.CURRYLAWGROUP.COM

**CLIENT INITIAL INFORMATION
QUESTIONNAIRE PERSONAL
INJURY (DOG BITE)**

For Office Use Only

Atty/Paralegal _____
Date Opened _____
SOL _____
File No. _____

GENERAL INFORMATION

The Attorney You Are Seeing: _____ Date _____
Who referred you to Curry Law Group, P.A.? _____
Have you seen our advertisements in/on: ☐ TV ☐ Phone Book _____ (which)
☐ Build Board _____ (where) ☐ Magazines ☐ Newspaper _____ (which)
Are You A Prior Client? YES or NO If Yes, When? _____
Name of Attorney the Represented You: _____

ABOUT YOU

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Cell: _____ Home: _____
Work: _____
Which phone do you prefer we call you? _____
Email: _____
DOB: _____ Social Security No. _____
Driver's License No. _____ State: _____
How long have you lived in Florida? _____
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse's Name (If Applicable): _____ Phone: _____
Spouse's Employer: _____ Work: _____
Children(s) Name(s) & Age(s):
1. _____ Age: _____ 3. _____ Age: _____
2. _____ Age: _____ 4. _____ Age: _____
Clubs and Activities: _____

ABOUT THE INCIDENT

Date of Incident: _____ City/State of Incident: _____

Location of Incident: _____

Describe briefly about incident: _____

Type and Breed of dog: _____

Do you have photographs/videos showing your injuries? _____

Was a report/claim filed: _____ If so, do you have report/claim info? _____

Name of Law Enforcement Agency that investigated your incident: _____

Witness Name & Address/Phone:

Witness Name & Address/Phone:

ABOUT THE ADVERSE PARTY

Name of Adverse Party: _____

Address: _____

City/State/Zip: _____

Phone: _____

Insurance Company: _____

Claim No./Adjuster: _____

ABOUT YOUR TREATMENT

Describe your injuries from this incident: _____

Were you treated in the hospital? _____ If yes, name of hospital: _____

If yes, were you transported to hospital by EMS? _____ Name of EMS: _____

Are you being treated by a physician for your injuries sustained in this incident? _____

If so, please list every physician and medical facility that you have treated with below:

Physician/Clinic Name & Address/Phone:

Physician/Clinic Name & Address/Phone:

Physician/Clinic Name & Address/Phone:

Physician/Clinic Name & Address/Phone:

ABOUT YOUR EMPLOYER

Employer's Name: _____

Address: _____ City/State/Zip: _____

Occupation: _____

Have you lost time from work due as a result of this incident: _____

If so, how long? _____

What is your average weekly salary: \$ _____ Gross No. of work hours: _____

ABOUT YOUR HEALTH INSURANCE (IF APPLICABLE)

Type of Insurance: (Check all that apply) **PLEASE PROVIDE INSURANCE CARD(S)**

☐ Personal ☐ Medicare ☐ Medicaid ☐ County Assistance

☐ Medicare Supplement/Replacement ☐ Other _____

Insurance Company: _____

Claims Address: _____

City/State/Zip: _____

Phone: _____

Policyholder Name: _____ Relationship to Policyholder: _____

Member/Plan ID: _____ Group No. _____