

DOUGLAS, LEONARD & GARVEY, P.C.
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NEW HAMPSHIRE AUTOMOBILE ACCIDENT CHECKLIST

I. General Information

Your Name _____ Date of Birth: _____

Address _____

Home Phone Number _____ Work Phone Number: _____

Marital Status: _____

E-Mail Address: _____

Your Social Security Number: _____

Current Employer: _____

Work Address: _____

Length of Time With Employer: _____

II. Your Insurance Carrier (or Agent if Company not known) _____

Address _____

Phone _____

Amounts of Your Car Liability Insurance \$ _____

Property Damage \$ _____ Medical Payments \$ _____

Collision \$ _____ Uninsured Motorist \$ _____

How much is your Deductible? \$ _____

Please attach or mail us a copy of your policy.

III. **Defendant** 1. _____ Age _____ Sex _____

Address _____

Phone # _____

Work Address _____

Work Phone # _____

Defendant's Insurance Carrier _____

Address _____ Phone _____

Amount of Insurance \$ _____

Collision \$ _____

Do you have photos of your motorcycle? _____

Do you have photos of your injuries? _____

Location/Address of Accident? _____

Did the Police Respond to the Accident? _____

What Police Department? _____

Witnesses to Accident

Name _____ Address _____ Age _____ Phone _____

Passengers in Your Car

Name Address Age Phone

Has your statement been recorded by the insurance company? _____

Were You Transported by Ambulance? _____

Ambulance Service – Name if applicable? _____

Hospital Name _____

Doctors (List every one for accident or aftercare)

Name Address

1. _____

Diagnosis & Treatment _____

Period or Dates of Visits or Treatments _____

Name Address

2. _____

Diagnosis & Treatment _____

Period or Dates of Visits or Treatments _____

Name

Address

3. _____

Diagnosis & Treatment _____

Period or Dates of Visits or Treatments _____

Name

Address

4. _____

Diagnosis & Treatment _____

Period or Dates of Visits and Treatments _____

IV. DAMAGES – PLAINTIFF

Your Employment Before & After Accident

<u>Before:</u>	Dates	Position	Earnings	Per Diem Or Hourly
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<u>After:</u>	Dates	Position	Earnings	Per Diem Or Hourly
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Lost Wages

() Past & Present to Date of Trial – Days in Hospital _____

() Past & Present Continued Days at Home _____ Returned to Work _____

On what Date? _____

() Total Days _____ X Per Diem Wages \$ _____

() Total Lost Wages _____

V. PRIOR TO THE ACCIDENT

Please list each and every motor vehicle or other accident in which you have been involved regardless of whether or not you were hurt:

Accident 1: _____ **Date:** _____

Location of accident: _____

Number of people involved: _____

Which party was responsible for damages: _____

If you were injured, which part of your body was injured: _____

Were you transported to a hospital? _____

Describe the medical treatment you received: _____

All hospitals, doctors, chiropractors, or therapists who treated you with respect to the accident listed above and the dates of said treatment, if known:

Name _____ Name _____

Address _____ Address _____

Dates _____

Accident 2: _____ **Date:** _____

Location of accident: _____

Number of people involved: _____

Which party was responsible for damages: _____

If you were injured, which part of your body was injured: _____

Were you transported to a hospital? _____

Describe the medical treatment you received: _____

All hospitals, doctors, chiropractors, or therapists who treated you with respect to the accident listed above:

Name _____ Name _____

Address _____ Address _____

(Use additional sheet of paper for other accidents)

VI. COMPLETE MEDICAL HISTORY

In order to go ahead with a personal injury case, it is important that we have a complete medical history. This includes all operations, workers' compensation

injuries, other injuries or medical problems that you have had in the past including the dates of such injuries or medical problems and the names of all doctors or health care providers who treated you. This remains confidential.

VII. MOTOR VEHICLE AND CRIMINAL HISTORY

Please list for our eyes only, all motor vehicle or criminal charges, arrests or convictions you have ever had. If none, say so: _____

Return to:

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