SMITH WATTS & ASSOCIATES, LLC
PERSONAL INJURY INFORMATION

DATE: _____

NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ EMPLOYER: _____

PHONE NUMBER (W): _____ SPOUSE: _____

(H): _____ DRIVER LICENSE #: _____

(C): _____ RACE: _____ SEX: _____

EMAIL: _____

TYPE OF INJURY: _____

DATE OF INJURY: _____

LOCATION OF INJURY: _____

WAS AN INCIDENT REPORT FILLED OUT: ___ YES ___ NO WERE POLICE CALLED: ___ YES ___ NO

WERE YOU TRANSPORTED TO HOSPITAL IN AMBULANCE: ___ YES ___ NO

DATE OF INITIAL TREATMENT: _____

WERE ANY X RAYS TAKEN: _____YES _____ NO

DETAILS OF HOW THIS INCIDENT OCCURRED: _____

_____

_____

_____

LIST ALL TREATEMENT FACILITIES: _____

_____

_____

_____

_____

LIST ALL PHARAMCIES YOU HAVE FILED PRESCRIPTIONS AT FOR THIS INCIDENT: _____

_____