JOEY GILBERT LAW

ATTORNEYS AT LAW
LICENSED IN NEVADA AND CALIFORNIA

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Today's Date: _______________

Your Personal Information

Full Legal Name: ____

Social Security No: ______________________________________ Date of Birth: ________/______/_______

Home No: ________________________________ Cell No: ____

Home Address: ____

City: _____________________________________ State: ______________ Zip Code: _________________

Driver's License No: ____

Email Address: ____

Marital Status: ☐ Single ☐ Married ☐ Partnered

Spouse's Full Legal Name: _______________________________Telephone Number: _________________

Did you serve in the armed forces? No ☐Yes ☐ Length of Time:_________________________________

Branch: ____ Service: ____________________________

Do you have Roommates or live with parents? No ☐Yes ☐ If so, please list all the names of your roommates and whether or not they have vehicle insurance: _______________________________________

____

____

Employment Information

Place of Employment:____

Address:____

Telephone Number: ________________________ Job Title: ____________________________

Length of Employment:________________Time lost from work to date (if any): ______________________

Rate of pay at the time of accident: ____

Information of the Vehicle YOU Were Driving:

Are you the policy holder? Yes ☐ No ☐ Listed/Authorized Driver? Yes ☐ No ☐

Is this vehicle registered under your name? Yes ☐ No ☐

Type of Vehicle: Make: _____________________ Model: ____________________Year: _______________

Auto Insurance Company: ____

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Policy No:______________________________________ Med. Pay Info: ___________________________

Policy Holder:___________________________________Claim Number: ___________________________

Name of vehicle owner: ____

Vehicle Damage Estimate: $_________________ Area of damage: ________________________________

Please list the auto insurance information for any vehicles insured under your name:

Vehicle #1: Make: _____________________ Model: ____________________Year: ______________

Vehicle #2: Make: _____________________ Model: ____________________Year: ______________

Auto Insurance Company: ____

Policy Number: _________________________________Claim Number: ___________________________

Telephone No: ___________________________ Name of Agent: ________________________________

Information about the Accident

Date of Incident: _____/______/______Time____:____ AM/PM Location: _________________________

What was the purpose of your trip? ________________________ Brief Description of Incident: ________

____

____

____

Were you a: ☐ Pedestrian ☐ Bicyclist ☐ Motorcyclist ☐ Driver ☐ Passenger

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Area of damage: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Approximate Speed of your vehicle: ☐ 0-15 mph. ☐ 25 mph. ☐ 35mph. ☐ 45 mph. ☐ 55 mph.

☐ 65 mph. ☐ 75 – mph. ☐ Other: ____

Was a Police Report Filed: **No** ☐ **Yes** ☐ If yes, with which department? ☐ Reno Police Department

☐ Sparks Police Department ☐ Carson City Sherriff's Department ☐ Nevada Highway Patrol

☐ Storey County Sherriff's Dept. ☐ Other: ____

Police Report Number: ____

List all occupants in the vehicle at the time of accident. (Please include addresses and phone numbers)

Driver ____

Passenger(s): ____

____

Were you rushed via **ambulance**? No ☐ Yes ☐ If yes, to which hospital? _________________________

Were you treated at an **emergency room**? No ☐ Yes ☐ If yes, in which emergency room? ___________

____

Have you had any out-of-pocket expenses as a result of this injury? Yes ☐ No ☐

If yes, please list: ____

Person/Driver AT-FAULT:

Name of responsible party/vehicle owner (if known): ____

Name of Auto Insurance: ________________________________ Phone Number: ____________________

Policy No: ______________________________ Claim No: ____

Year of vehicle: _____________ Make: _____________________ Model: __________________________

Approximate Speed of at-fault vehicle: ☐ 0-15 mph. ☐ 25 mph. ☐ 35mph. ☐ 45 mph. ☐ 55 mph.

☐ 65 mph. ☐ 75 – mph. ☐ Other: ____

Attorney of responsible Party (if known):____

Address:__________________________City:________________State:________Zip Code:____________

Information about your Injuries

Please describe your injury and/or your PRESENT complaints and symptoms: ______________________

____

____

____

____

Please list all current/previous medical providers relating to this accident:

Medical Provider	Address	Telephone Number
1. ________________	______________________________	____________________
2. ________________	______________________________	____________________
3. ________________	______________________________	____________________
4. ________________	______________________________	____________________

Past Injury History

In the **last 5 YEARS** have you been involved in an automobile accident? ☐ Yes ☐ No

If yes, please list the date and describe any injuries suffered:

Accident 1: ____

Accident 2: ____

Accident 3: ____

Have you EVER been involved in a Worker's Compensation claim/case? ☐ Yes ☐ No

If yes, please describe, including date(s), and injuries sustained:

Accident 1: ____

Accident 2: ____

Accident 3: ____

Please list any pre-existing injuries or medical conditions not covered above and date of injuries/illness's: ____

____

____

____

Health Insurance Information

Select all that apply: Please provide copies of card, paperwork or proof of the box selected.

☐ Medicaid ☐ MedCal ☐ MedPay ☐ Medicare

☐ Private Health Insurance: ______________________ ☐ Other: ______________________

The following information is requested pursuant to Federal Law, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007:

Are you currently eligible for or covered by Medicare? Yes ☐ No ☐

If yes, what is your Medicare Health Insurance Claim Number? ______________________

Has Medicare paid/billed for any of your medical expenses related to this accident? Yes ☐ No ☐

How did you hear about Joey Gilbert Law?

☐ Referral: ______________________ ☐ Internet Search: ______________________

☐ Radio (list station): ______________________ ☐ TV (list provider): ______________________

☐ Billboard (location): ______________________ ☐ Other: ______________________

Evaluating your case:
Please be advised we have a "Review Period" in which our law firm will gather facts, request reports and medical records so we may accurately evaluate your claim. This "Review Period" usually lasts 15-20 business days. This period will start the day you come into our law firm and authorize us to represent you. This process will determine if our law firm may help you or if you will be better served on your own. Our case load is on a first-come first-serve basis and we kindly request your patience and to please hold any questions or comments until after the "Review Period" is over, someone from our law firm will contact you shortly thereafter.

I understand that the information furnished above, with the exception of that provided in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007, is to establish my entitlement to legal representation by Joey Gilbert Law. I affirm that the information provided above is true and correct to the best of my knowledge.

For your protection please be advised of the following: Any person who knowingly presents a false or fraudulent insurance claim for the payment of a loss may be guilty of a crime and may be subject to fines and confinement in a state prison.

Signature: ______________________ Date: ________/_____/________