SCHUETTE LAW GROUP

Brian Schuette (KY, TN)
Ashlea Shepherd Porter (KY)
Amanda Blakeman (KY)

VITAL INFORMATION

FILE ASSIGNED TO: Attorney:_____ Legal Assistant:_____

CLIENT:

_____	_____
Name (and name of child if applicable)	Place of employment
_____	_____
Street address or Post Office Box	Employer Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Telephone Number(s)	Telephone Number(s)
_____	_____
Social Security Number	Date of Birth
_____	_____
Driver, Passenger, Pedestrian	Name of Spouse

ACCIDENT:

_____	_____
Date of Accident	Adverse Driver
_____	_____
City and County	Address
_____	_____
Investigating Agency	City, State, Zip Code

719 Dishman Lane Ext.
Bowling Green, KY 42104
(270) 781-7500 Voice
(270) 781-7533 Facsimile
www.slg.legal

INSURANCE COMPANIES

COMPANY #1	COMPANY #2
_____	_____
Type of coverage (PIP, Liability, etc)	Type of coverage (PIP, Liability, etc)
_____	_____
Name of Company	Name of Company
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Telephone Number(s)	Telephone Number(s)
_____	_____
Adjuster	Adjuster
_____	_____
Claim Number	Claim Number
_____	_____
Named Insured	Named Insured
_____	_____
Additional Insured	Additional Insured

ADDITIONAL INSURANCE COMPANIES

COMPANY #_____

_____
Type of coverage (PIP, Liability, etc)

_____
Name of Company

_____
Address

_____
City, State, Zip Code

_____
Telephone Number(s)

_____
Adjuster

_____
Claim Number

_____
Named Insured

_____
Additional Insured

COMPANY #_____

_____
Type of coverage (PIP, Liability, etc)

_____
Name of Company

_____
Address

_____
City, State, Zip Code

_____
Telephone Number(s)

_____
Adjuster

_____
Claim Number

_____
Named Insured

_____
Additional Insured

MEDICAL PROVIDERS

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

MEDICAL PROVIDERS

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

MEDICAL PROVIDERS

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
Phone Number	Phone Number
Dates of Treatment_____	Dates of Treatment_____
Account #_____	Account #_____
Records Ordered_____	Records Ordered_____
Records Received_____	Records Received_____

CHRONOLOGY OF TREATMENT

PRIOR MEDICAL HISTORY / INJURIES

SUMMARY OF ACCIDENT FACTS

SUMMARY OF INJURIES

COVERAGES CHECKLIST

PIP (No Fault)

On Car:
Other:
Added reparation benefits?
Copy of dec sheet obtained?

LIABILITY

On adverse car:
On adverse driver:
On adverse driver's spouse, employer, parent, household:

UIM

On car:
On plaintiff:
On plaintiff's spouse, employer, parent, household:

HEALTH INSURANCE

On client:
On client's spouse:

WORKER'S COMPENSATION

If work related.

MED PAY

Review dec sheet to determine