

**LAW OFFICE OF DOMINGUEZ & ASSOCIATES, P.A.**

**ATTORNEYS AT LAW**

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**PERSONAL AND FAMILY HISTORY**

1. Your full name: \_\_\_\_\_  
Present home address: \_\_\_\_\_  
Present business address: \_\_\_\_\_  
Present home telephone (including area code): \_\_\_\_\_  
Present business telephone (including area code): \_\_\_\_\_
2. Social Security number: \_\_\_\_\_
3. Have you ever used, or been known by, any name other than the name shown above? If so, list the other names, and state when and why the other names were used.  
\_\_\_\_\_  
\_\_\_\_\_
4. Addresses where you have resided during the past 10 years, and the period of time at each residence, including dates:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Where were you born? \_\_\_\_\_  
When? \_\_\_\_\_
  - a. Have you ever used any other birth date or birthplace?  
\_\_\_\_\_
  - b. If so, give details: \_\_\_\_\_  
\_\_\_\_\_

6. Are you married? \_\_\_\_\_

Date of marriage: \_\_\_\_\_ Place: \_\_\_\_\_

What is the full name of your spouse?

\_\_\_\_\_

Are you living together now? \_\_\_\_\_

Have you been previously married? \_\_\_\_\_

If so, list the names and addresses of prior spouses:

\_\_\_\_\_

\_\_\_\_\_

Have you ever been divorced or legally separated? \_\_\_\_\_

If so, from whom, when, and where? \_\_\_\_\_

\_\_\_\_\_

7. List the names, addresses, and ages of all those (including children) who are dependent on you for support, and your relationship to each.

Name

Address

Age

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### THE ACCIDENT

8. Date: \_\_\_\_\_ Time: \_\_\_\_\_

Municipality: \_\_\_\_\_ County: \_\_\_\_\_

Daylight \_\_\_\_\_ Dark \_\_\_\_\_ Weather conditions: \_\_\_\_\_

Describe the location of accident (as to intersections or fixed object):

\_\_\_\_\_

\_\_\_\_\_

Police department investigating the accident: \_\_\_\_\_

In your own words, give a comprehensive account of the facts leading up to, during, and following the accident or incident you are complaining about:

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How did you leave the scene of the accident?

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Were photographs or videotapes taken at the scene of the accident?

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If so, please state the name and address of the person who took them and the person who has possession of them:

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Was the news media present at the scene? \_\_\_\_\_

If so, which station or newspaper? \_\_\_\_\_

Were you questioned by the police? \_\_\_\_\_

Did you give or sign a statement? \_\_\_\_\_

For whom? \_\_\_\_\_ When? \_\_\_\_\_

Do you have a copy of the statement or statements? \_\_\_\_\_

Have you been questioned by an insurance adjuster or investigator?

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When? \_\_\_\_\_ Where? \_\_\_\_\_

Name of person who questioned you? \_\_\_\_\_

Was anyone else present? \_\_\_\_\_

Did you sign any papers? \_\_\_\_\_

Were you given a copy? \_\_\_\_\_

Please list below everything you believe the defendant did that caused or contributed to the cause of the accident.

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DIAGRAM OF ACCIDENT

On the reverse side of this page, please draw a detailed diagram of the accident scene and vehicles.

WITNESSES

9. Provide us with a list of all witnesses and their addresses, and any other people who may be of assistance in testifying about your case.

Name

Address

Relationship

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VEHICLES INVOLVED IN THE ACCIDENT

10. Please provide the following information relating to your vehicle:

Make and model: \_\_\_\_\_

Model year: \_\_\_\_\_

License tag number: \_\_\_\_\_

Names of all persons who have an ownership interest: \_\_\_\_\_

\_\_\_\_\_

If the vehicle is financed, name of finance company:

\_\_\_\_\_

Location of vehicle at the present time: \_\_\_\_\_

Has anyone taken photographs of the vehicle? \_\_\_\_\_

If so, please state the name and address of the person who took them and who has possession of the photographs:

\_\_\_\_\_

\_\_\_\_\_

### INJURIES AND DAMAGES FROM THIS ACCIDENT

11. State all injuries known or believed by you to have been received as a result of this accident:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Disability — length of time confined to bed: \_\_\_\_\_

and thereafter to house: \_\_\_\_\_

State your present physical condition — scars, disabilities, deformities, discomforts — resulting from the injuries received in this accident:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Activities eliminated or hampered as a result of this injury. List here all the usual activities that you have NOT been able to perform since the accident, such as cutting grass, dancing, etc.:

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Has anyone taken photographs or videotapes of your injuries?

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If so, please state the name and address of the person who took them and the person who has possession of them:

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MEDICAL TREATMENT AND HOSPITALIZATION  
AS A RESULT OF THIS ACCIDENT

12. (a) Hospitalizations.

Name and address of hospital: \_\_\_\_\_

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Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

Why admitted: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

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Name and address of hospital: \_\_\_\_\_

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Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

Why admitted: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

(b) All physicians and surgeons who have seen or treated you as a result of this accident.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Date care began: \_\_\_\_\_ Still under care? \_\_\_\_\_

\* \* \*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Date care began: \_\_\_\_\_ Still under care? \_\_\_\_\_

(c) All nurses or therapists who have treated you as a result of this accident or incident.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Date care began: \_\_\_\_\_ Still under care? \_\_\_\_\_

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_

Date care began: \_\_\_\_\_ Still under care? \_\_\_\_\_

“OUT-OF-POCKET” EXPENSES  
OR OBLIGATIONS YOU NOW CLAIM

13. (a) Hospitals Amount

\_\_\_\_\_  
\_\_\_\_\_

(b) Doctors Amount

\_\_\_\_\_

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(c) Nurses and Therapists Amount

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(d) Medical Appliances Amount

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(e) Drugs and Medicines Amount

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(f) Ambulance Amount

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(g) Domestic/Household Help Amount

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(h) Transportation Expenses Amount

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(i) Property Damage Amount

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(j) Miscellaneous Expenses Amount

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NOTE: PLEASE KEEP ALL BILLS AND RECEIPTS AND TURN THEM OVER TO YOUR ATTORNEY.

INSURANCE AND WORKERS' COMPENSATION

14. Your Automobile Insurance

Name and address of automobile insurance company:

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Policy number: \_\_\_\_\_

Claim number: \_\_\_\_\_

Adjuster's name: \_\_\_\_\_

Vehicles listed on policy: \_\_\_\_\_

Personal injury protection coverage? \_\_\_\_\_

Liability coverage? \_\_\_\_\_ Amount: \_\_\_\_\_

Uninsured motorist coverage? \_\_\_\_\_ Amount: \_\_\_\_\_

Medical payments coverage? \_\_\_\_\_ Amount: \_\_\_\_\_

Collision insurance? \_\_\_\_\_ Deductible amount: \_\_\_\_\_

Health Insurance

Name and address of health insurance company:

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Policy number: \_\_\_\_\_

Workers' Compensation

Were you injured on the job in this accident? \_\_\_\_\_

Are you receiving payments at present? \_\_\_\_\_

If so, explain: \_\_\_\_\_

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Name and address of the attorneys who are handling the workers' compensation at present:

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Social Security or Medicare

Have you received social security benefits or Medicare benefits as a result of this accident?

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EDUCATIONAL BACKGROUND

15. What education have you had, including any special employment training?

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WORK BACKGROUND

16. Were you employed at the time of the accident? \_\_\_\_\_

- a. If so, state name and address of employer:  
\_\_\_\_\_
- b. What was your job title, or what type of work you were doing?  
\_\_\_\_\_
- c. What was your rate of pay? \_\_\_\_\_
- d. How many hours per week were you regularly working immediately before the accident?  
\_\_\_\_\_
- e. When were you first employed by the company for which you were working at the time of the accident?  
\_\_\_\_\_
- f. Have you remained in the same job since that date? \_\_\_\_\_
- g. If not, state the reason for the termination of employment:  
\_\_\_\_\_
- h. Have you missed any time from work as a result of your injury? If so, list the dates you were unable to work because of your injury:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- i. Have you, BEFORE this accident, lost time from work because of an injury? \_\_\_\_\_ If so, give details:  
\_\_\_\_\_  
\_\_\_\_\_
- j. Did you lose wages for the periods of time missed from work because of this accident? \_\_\_\_\_  
If so, state the total loss to date: \_\_\_\_\_
- k. Have you received any increases or decreases in your pay since the accident? \_\_\_\_\_  
If so, explain:  
\_\_\_\_\_

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1. If you have changed jobs since the accident, give a summary of your present job, showing name and address of employer, rate of pay, hours, and type of work performed:

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EMPLOYMENT RECORD

17. List your employment record as far back as you can remember. Your past employment record is important in determining your disability from an occupational viewpoint.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

Job: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

Job: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\* \* \*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

Job: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\* \* \*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

Job: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\* \* \*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employed from: \_\_\_\_\_ to: \_\_\_\_\_

Job: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

MILITARY BACKGROUND

18. Have you ever been rejected for military service because of physical, mental, or other reasons? \_\_\_\_\_

a. If so, explain: \_\_\_\_\_

\_\_\_\_\_

b. Have you ever served in the military? \_\_\_\_\_ If so, please state branch of military:

\_\_\_\_\_

Service Serial No.: \_\_\_\_\_

Dates of service. From: \_\_\_\_\_ To: \_\_\_\_\_

Type of discharge: \_\_\_\_\_

c. Any service-connected injuries or disabilities? \_\_\_\_\_

Details: \_\_\_\_\_

d. Percentage of disability: \_\_\_\_\_

Present condition of service-connected injury or disability:

\_\_\_\_\_

Do you receive payments for service-connected injuries or disability? \_\_\_\_\_

PRIOR CLAIMS AND LAWSUITS

19. We know there have been many cases damaged beyond repair by a history of other claims and lawsuits that the attorney did not know about. It is NOT the fact that one has had other claims or lawsuits that is important, for one will not be penalized by a court or jury if the claims are reasonable and genuine. It is the DENIAL of previous claims and lawsuits that damages the case. List every claim you have ever made for personal injury or property damage, and give details. This includes claims under the state workers' compensation laws, Railroad Sickness Benefits, and the Longshore and Harbor Workers' Compensation Act. If you have made no claims and filed no lawsuits, please state "none."

Date: \_\_\_\_\_ Nature of claim: \_\_\_\_\_

Against whom: \_\_\_\_\_

Suit filed: \_\_\_\_\_

Result: \_\_\_\_\_

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Date: \_\_\_\_\_ Nature of claim: \_\_\_\_\_

Against whom: \_\_\_\_\_

Suit filed: \_\_\_\_\_

Result: \_\_\_\_\_

PRIOR ACCIDENTS AND INJURIES

20. Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem. List here every prior incident, whether it resulted in a claim for damages or not, stating the date, place, and nature of the accident, and the extent of your injuries. If you have had no prior accidents or injuries, please state "none."

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Nature of accident or injury: \_\_\_\_\_

Extent of injury: \_\_\_\_\_

Name of doctors and hospitals, and their addresses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* \* \*

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Nature of accident or injury: \_\_\_\_\_

Extent of injury: \_\_\_\_\_

Name of doctors and hospitals, and their addresses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL HISTORY

21. Prior Physical Examinations

List here EVERY physical examination you have had during the last 10 years for employment promotion, insurance, selective service, armed forces, and others, stating the date, name of the doctor, and result, as fully as you can recall.

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Purpose: \_\_\_\_\_ Result: \_\_\_\_\_

\* \* \*

Date: \_\_\_\_\_ Place: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

Purpose: \_\_\_\_\_ Result: \_\_\_\_\_

ACCIDENTS OR INJURIES AFTER THIS ACCIDENT

22. If you have had ANY accident or injury since the one for which we are representing you, please state concerning each:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Place: \_\_\_\_\_

How it happened: \_\_\_\_\_

\_\_\_\_\_

Were you insured? \_\_\_\_\_ By whom? \_\_\_\_\_

Names and dates of medical treatment or hospitalization and names and addresses of treating physicians:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

POLICE RECORD

23. It is the law in this state and elsewhere that if a person has a criminal record, no matter how long ago, nor how mitigating the circumstances, that fact under certain circumstances may be proved against that party and commented on at the trial of the case. The denial of a criminal record increases the chance that the subject may be brought up at trial. The defense lawyers will thoroughly investigate your background. Therefore, it is extremely important that you discuss any criminal matter with your attorney. Please indicate below if you have a criminal record and discuss it with us as soon as possible.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Electronic Signature: Typing your name(s) below will have the same effect as your signature. You may fill out the form, print your name(s), date the form, and email it to us.

Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please email this form to [cesar@dominguezassociateslaw.com](mailto:cesar@dominguezassociateslaw.com)