

Automobile Accident Questionnaire

GUEST LAW FIRM

Please answer all questions completely, then contact Guest Law Firm for further insight.

James B. Guest, Attorney at Law
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VICTIM'S CONTACT INFORMATION

First and last name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Name of insurance company: _____

Policy number: _____

Claim number: _____

Phone number: _____

Driver's license number: _____

OTHER DRIVER'S INFORMATION

Name of the driver of the other vehicle causing accident: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone number: _____

Name of insurance company: _____

Policy number: _____

Claim number: _____

Phone number: _____

Driver's license number: _____

ACCIDENT INFORMATION

Please explain in detail how your accident happened:

Injured was: Driver Passenger Pedestrian

Number of people in vehicle: _____

Date of accident: _____ Time of accident: _____

Number of vehicles involved: _____

Accident occurred on (check one):

- Interstate Parish road US highway
 City street State highway Private property
 Other: _____

Did head strike windshield or object? Yes No

Did airbag deploy? Yes No

Were you knocked unconscious? Yes No

If so, for how long? _____

You were struck from:

- Behind Front Left side Right side

Did you feel pain immediately after the accident?

- Yes No

If so, where? _____

Was paramedic treatment rendered? Yes No

If so, to what areas? _____

Have you ever had any complaints in the involved area before?

- Yes No

If so, when and where were the complaints? _____

Please notify the police and obtain an accident report.

This document is essential when pursuing an injury claim.

Once completed, please save and email to jim@guestlawoffice.com, or print and bring with you to your scheduled meeting with Mr. Guest.