# RONALD L. BELL & ASSOCIATES, P.C.

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## CLIENT INFORMATION INTAKE

DATE: _____

NAME: _____

ADDRESS: _____

_____
(City) (State) (Zip)

HOME PHONE: _____

CELLULAR: _____

WORK PHONE: _____ EXT: _____

**E-MAIL:** _____

DATE OF BIRTH: _____ PLACE OF BIRTH _____

SOCIAL SECURITY NUMBER: _____

NATURE OF THIS MATTER: _____

NAME & ADDRESS OF OPPOSING PARTY:

_____
_____
_____

OPPOSING PARTY ATTORNEY (IF KNOWN):

_____
_____
_____

EXISTING COURT DATE & INFO: _____
(If known) (Date) (Time)

_____
(Courthouse) (Room)

HOW WERE YOU REFERRED TO US: YELLOW PAGES / INTERNET / FRIEND / OTHER

**IF THIS MATTER IS CONCERNING DIVORCE, CHILD SUPPORT, OR CUSTODY,
PLEASE PROCEED TO THE QUESTIONS ON PAGES 2 & 3**

**IF THIS MATTER IS CONCERNING AN ACCIDENT/INJURY,
PLEASE PROCEED TO THE QUESTIONS ON PAGE 4**

## FOR MATTERS CONCERNING DIVORCE, SUPPORT, OR CUSTODY

**SPOUSE/PARTNER INFORMATION**:

NAME: _____

WIFE'S MAIDEN NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBER(S): _____

E-MAIL: _____

DATE OF BIRTH: _____ PLACE OF BIRTH _____

SOCIAL SECURITY NUMBER: _____

DATE OF MARRIAGE: _____

LOCATION OF MARRIAGE: _____
(City) (County) (State)

CHILDREN BORN OR ADOPTED OF THIS MARRIAGE

| Name of Child | Date of Birth | School | Primary Possession |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

OCCUPATION HUSBAND: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER TELEPHONE: _____

GROSS ANNUAL INCOME: $ _____

OCCUPATION WIFE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER TELEPHONE: _____

GROSS ANNUAL INCOME: $_____

| **AUTOMOBILES** | YEAR | MAKE/MODEL |
|---|---|---|
| HUSBAND | | |
| WIFE | | |

REAL ESTATE OWNED: _____

[ ] DOMESTIC VIOLENCE: _____

[ ] ORDER OF PROTECTION:

## FOR MATTERS CONCERNING ACCIDENT/INJURY

DATE OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

INJURIES SUSTAINED: _____

TREATING HOSPITAL: _____

TREATING PHYSICIAN(S): _____

_____

_____

_____

_____

_____

**ARE YOU STILL RECEIVING TREATMENT FOR YOUR INJURIES? Y / N**

AMOUNT OF MEDICAL (IF KNOWN) $_____

YOUR INSURANCE COMPANY: _____

POLICY NUMBER: _____

**OTHER PARTY'S INFORMATION**:

INSURANCE COMPANY: _____

POLICY NUMBER: _____

NAME OF DRIVER: _____

NAME OF INSURED: _____

ADDRESS & PHONE: _____

CLAIM NUMBER (IF KNOWN): _____

ADJUSTER (IF KNOWN): _____