

**NO-FAULT OR PERSONAL INJURY ACCIDENT INFORMATION**

Please answer every question.

Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

How did accident occur?  Auto Collision  Other \_\_\_\_\_

If auto accident, you were  Driver  Passenger  Pedestrian

If auto collision, you were struck from  Behind  Right Side  Left Side  Front  Auto was Parked

Did your car strike the other(s) involved?  Yes  No

Or did the other car strike yours?  Yes  No  Undetermined

Were you wearing a seat belt and shoulder belt?  Yes  No

As a result of the accident, were traffic citations issued to you?  Yes  No

To the driver of the other car?  Yes  No

To the driver of your car?  Yes  No

Was the vehicle equipped with Air bags?  Yes  No If so, did the Air bags release?  Yes  No

Was a Police Report Filed?  Yes  No Which Police Department? \_\_\_\_\_

List the extent of the injuries as you know them \_\_\_\_\_

\_\_\_\_\_

Were you treated or evaluated at an Emergency Room?  Yes  No Where? \_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No Where? \_\_\_\_\_

Were x-rays taken?  Yes  No Where? \_\_\_\_\_

Indicate the symptoms you have noticed since the accident:

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="radio"/> Headaches        | <input type="radio"/> Dizziness             | <input type="radio"/> Light Bothers Eyes | <input type="radio"/> Diarrhea      |
| <input type="radio"/> Neck Pain        | <input type="radio"/> Head Seems Heavy      | <input type="radio"/> Loss of Memory     | <input type="radio"/> Feet Cold     |
| <input type="radio"/> Neck Stiff       | <input type="radio"/> Pins & Needles in Arm | <input type="radio"/> Ears Ring          | <input type="radio"/> Hands Cold    |
| <input type="radio"/> Sleeping Problem | <input type="radio"/> Pins & Needles in Leg | <input type="radio"/> Face Flushed       | <input type="radio"/> Stomach Upset |
| <input type="radio"/> Back Pain        | <input type="radio"/> Numbness in Fingers   | <input type="radio"/> Buzzing in Ears    | <input type="radio"/> Constipation  |
| <input type="radio"/> Nervousness      | <input type="radio"/> Numbness in Toes      | <input type="radio"/> Loss of Balance    | <input type="radio"/> Cold Sweats   |
| <input type="radio"/> Tension          | <input type="radio"/> Shortness of Breath   | <input type="radio"/> Fainting           | <input type="radio"/> Fever         |
| <input type="radio"/> Irritability     | <input type="radio"/> Fatigue               | <input type="radio"/> Loss of Smell      | <input type="radio"/> Other _____   |

Symptoms other than above \_\_\_\_\_

Have you lost any days of work?  Yes  No Dates: \_\_\_\_\_

Insurance Companies involved:

My Company \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Company or person responsible for injuries \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?  Yes  No

Do you have an attorney that has advised you in this case?  Yes  No

Attorney's Name \_\_\_\_\_ Address \_\_\_\_\_

Telephone \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM  
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, \_\_\_\_\_, ("Assignor") hereby assign to Greater Rochester Chiropractic, ("Assignee")  
(Print patient's name)

all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to motor vehicle accident which occurred on \_\_\_\_\_, not withstanding any other agreement to the contrary.  
(Print accident date)

This agreement may be revoked by the assignee when the benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

\_\_\_\_\_  
(Print name of Patient)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_

\_\_\_\_\_  
(Date of signature)

\_\_\_\_\_  
(Address)

Greater Rochester Chiropractic  
30 Allens Creek Road  
Rochester, NY 14618  
(585) 442-3220

\_\_\_\_\_  
(Signature of Provider)

\_\_\_\_\_  
(Date of signature)