

PATIENT REGISTRATION MOTOR VEHICLE ACCIDENT / NO FAULT

Today's Date: _____

PATIENT INFORMATION

Name: _____
 Name Preferred to Be Called: _____
 Date of Birth: _____
 Social Security #: _____
 Mailing Address: _____
 City, State, Zip: _____

Marital Status:
 Single Married Divorced Separated Widowed
 Home Phone #: _____
 Cell Phone #: _____
 Work Phone #: _____ Ext: _____
 Email Address: _____
 Referred To Us By: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____
 Street Address: _____
 City, State, Zip: _____

Clinic Name: _____
 Phone #: _____
 Fax #: _____

NO-FAULT INSURANCE INFORMATION

Date of Injury: _____
 Injured Areas of the Body: _____
 No Fault Insurance Carrier: _____
 Insured's Name: _____
 Policy #: _____
 Claim #: _____
 Examiner's Name: _____
 Examiner's Phone #: _____ Ext: _____
 Examiner's Fax #: _____

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: _____
 Policy Holder: _____
 Policy Holder's Birthday: _____
 Policy #: _____

ATTORNEY INFORMATION

Attorney Name: _____
 Attorney Address: _____
 City, State, Zip: _____
 Attorney Phone #: _____ Fax #: _____

IN CASE OF EMERGENCY

Please Contact: _____
 Relationship to Patient: _____

Home Phone #: _____
 Alternate Phone #: _____

Assignment & Release - By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

 Patient / Guardian

 Date

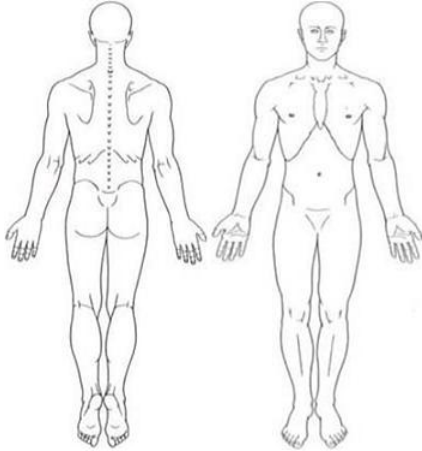
PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____

1. What is the reason for your visit today? _____

- a. Approximately when did this current episode start? _____
- b. What brought on this current episode? _____
- c. Is this episode a worsening of a prior injury? No Yes, it was: Work-related Auto Accident Other

2. Location: Where does it hurt?



3. Nature of Symptoms

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- _____
- _____

4. Intensity of Symptoms:

- None Mild Moderate Severe
- Currently: 0 1 2 3 4 5 6 7 8 9 10
- At its worst: 0 1 2 3 4 5 6 7 8 9 10
- At its best: 0 1 2 3 4 5 6 7 8 9 10

5. Duration: How often do you experience symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (56-50% of the day)
- Intermittently (0-25% of the day)

6. Aggravating or Relieving Factors:

What makes your symptoms worse? _____

What makes your symptoms better? _____

7. Prior Treatment: What have you done to relieve the symptoms?

- Chiropractic Acupuncture Prescription Meds: _____
- Physical Therapy Massage Over-the-Counter Meds: _____
- Surgery _____ Homeopathic Remedies: _____

8. Activities of Daily Living: How much does this condition interfere with your life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Driving/Riding in a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Social life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard Work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. What is your current work status?

- Working – Full Duty Unemployed..... last date worked _____/_____/_____
- Working – Modified Duty Retired..... last date worked _____/_____/_____

10. What is your current occupation?

- Homemaker Full-Time Student Retired _____

11. Current: Height _____ feet _____ inches **Weight** _____ pounds **Smoking Status:** _____

12. Additional Comments: _____

Patient Signature _____ **Date** _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

Motor Vehicle Accident Indemnification Corporation
110 WILLIAM STREET
NEW YORK, N.Y. 10038

DATE	POLICY HOLDER	POLICY NUMBER <p style="text-align: center;">N/A</p>	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT

1. YOUR NAME		2. PHONE NOS.		HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)				4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT			7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE		
			A.M. P.M.		

8. BRIEF DESCRIPTION OF ACCIDENT:

9. DESCRIBE YOUR INJURY:

<p>10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF ACCIDENT:</p> <table style="width: 100%;"> <tr> <td style="width: 30%;"><u>OWNER'S NAME</u></td> <td style="width: 30%;"><u>MAKE</u></td> <td style="width: 30%;"><u>YEAR</u></td> </tr> </table> <p>THIS VEHICLE WAS:</p> <p><input type="checkbox"/> A TRUCK, OR <input type="checkbox"/> A BUS OR SCHOOL BUS</p> <p><input type="checkbox"/> A MOTORCYCLE <input type="checkbox"/> AN AUTOMOBILE</p>	<u>OWNER'S NAME</u>	<u>MAKE</u>	<u>YEAR</u>	<p>11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A PASSENGER IN THE MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A PEDESTRIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<u>OWNER'S NAME</u>	<u>MAKE</u>	<u>YEAR</u>		

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES? YES NO

NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN: OUT-PATIENT IN-PATIENT

DATE OF ADMISSION: HOSPITAL'S NAME AND ADDRESS:

14. AMOUNT OF HEALTH BILLS TO DATE \$ _____	15. WILL YOU HAVE MORE HEALTH TREATMENTS(S) <input type="checkbox"/> YES <input type="checkbox"/> NO	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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17. DID YOU LOSE TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE RETURNED TO WORK:
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AMOUNT OF TIME LOST FROM WORK:	18. WHAT ARE YOUR AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:
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19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT? YES NO

(Continued on next page)

BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

(Page 2)

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO
IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING
NEW YORK STATE DISABILITY? YES NO
WORKERS' COMPENSATION? YES NO

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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.

SIGNATURE: _____ DATE: _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

• BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

**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 _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider 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 the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when 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 COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, 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 VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)