Patient Intake Form

General Information

Patient name _____ Sex M__ F__ DOB__/__/ _____

Address _____ City_____ State_____ Zip _____

Phone(Home)_____ Cell & cell carrier _____ Work_____

Email Address _____

Emergency Contact _____ Phone_____

Address _____Relationship _____

Employment (circle) Full Time Part Time Retired Not Employed Student

Employer _____ Employer Phone # _____

Insurance provider_____ Insurance ID # _____

Who referred you today? _____

___ Friend/Family member ___Promo ___Internet ___Phonebook ___Other

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Atlas Chiropractic of Syracuse, P.L.L.C. will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Atlas Chiropractic of Syracuse, P.L.L.C. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If I choose to suspend or terminate my care at this office, any outstanding charges for professional services rendered to me are immediately due and payable. I agree that I am responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Atlas Chiropractic of Syracuse, P.L.L.C. to obtain a credit report if deemed necessary.

I understand and am informed that, as in all other healthcare offices, in the practice of chiropractic, there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocation, disc injuries, and strokes. I understand that I cannot expect the doctors to anticipate all risks and complications that may result from treatment. I wish to rely on the doctors to exercise judgment during the course of the treatment, which they feel at the time, based upon the facts known, and are in my best interest.

I have read, or have had read to me, the above consent and release, and have had the opportunity to ask questions about its content.

Patient signature _____ Date _____

Guardian signature authorizing care _____ Date _____

Please check all that apply:

__ Fractured Bones
__ Auto Accidents
__ 0-1 Years Ago
__ 1-5 Years Ago
__ Over 5 Years Ago
__ Other Accidents/Falls
__ Arthritis
__ Diabetes
__ Convulsions, epilepsy
__ Skin Problems
__ Cancer
__ Frequent Colds, Flu
__ Depressed
__ Irritable
__ Anemia
__ Allergies, Sinus
__ Under extreme stress
__ Eating disorders
__ Trouble Sleeping
__ Trouble concentrating
__ Learning Disability
__ Mood Changes

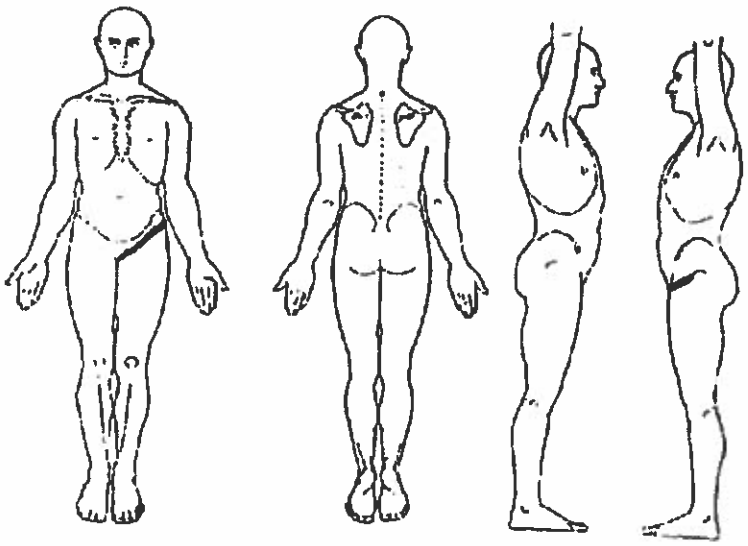
__ Neck Pain or Stiffness R L
__ Numbness, tingling, or Pain in arms, hands, or Fingers R L
__ Jaw Pain or Click (TMJ) R L
__ Difficulty in excessive Twisting, standing, sitting, Riding, bending, or lifting
__ Shoulder Pain R L
__ Dizziness
__ Ringing in ears R L
__ Hearing Loss
__ Blurred or Double Vision
__ Upper back pain, stiffness
__ Mid back pain, stiffness
__ Lower back pain, stiffness
__ Pain with cough, sneeze
__ Hip pain R L
__ Headaches

__ Numbness, tingling, pain In buttocks, legs, feet, toes R L
__ Foot trouble R L
__ Chest pain, asthma
__ Heart problems
__ Stroke
__ High/Low blood pressure
__ Varicose Veins
__ Liver trouble
__ Gall bladder trouble
__ Digestive problems
__ Ulcers
__ Hemorrhoids
__ Prostate problems
__ Impotence
__ Kidney trouble
__ Menstrual Problems PMS
__ Pregnant (now)
__ Bedwetting
__ Ear Infections
__ AIDS,HIV

Please mark the area of injury or discomfort on the diagram below using the appropriate symbols.

Numbness: - - - - - - - - **Aching:** XXXXXXXXX **Burning:** ^^^^^^^^

Pins & Needles: o o o o o o **Stabbing:** ssssss



Initial visit

PCP: Karoly Toth D.C.

Complaint: 1._____ 2._____ 3._____

Is the injury accident related? _____Motor Vehicle/ _____ Work accident/ If yes, when?_____

Date of onset (of complaint): 1. _____2. _____3. _____

Location (of complaint): 1._____2. _____3. _____

Neurological (numbness/tingling in extremities) (circle) yes no
Location (of numbness and/or tingling) 1. _____2. _____3. _____

Radiation/Referral (of pain to other parts of the body): (circle) yes no
location(of radiating pain): 1. _____2. _____3. _____

Quality (sharp, shooting, dull etc. of complaint) 1. _____2. _____ 3._____

Timing/Frequency (how long and how frequent of complaint):
1. _____ 2._____3. _____

Palliative (what makes the complaint better): 1._____2. _____3. _____
Provocative (what aggravates the complaint): 1. _____2. _____3. _____

Review of Systems: Is documented in the chart on the new patient intake sheet dated today's date. It was reviewed with patient and felt to be non-contributory, and if applicable-with the exception of

Past Medical History: _____
_____
_____
_____

Past Surgical History: _____
_____

Current medications:_____
_____

Allergies: _____
_____

Social History:
Psych ( ) Patient is awake, alert and oriented to person, place and time. Patient affect is appropriate to the situation. They are good/poor historian requiring little/moderate/ considerable prompting
( ) Abnormal: (specify) _____
_____
Smoker: ( )yes ( ) no Details: _____
ETOH/Substance: _____ MVA/Trauma: _____

ANTHONY'S BODYWORKS STUDIO
ATLAS CHIROPRACTIC OF SYRACUSE P.L.L.C.
141 SHOP CITY PLAZA
SYRACUSE, N.Y. 13206

Phone: (315) 414-0224

Fax: (315) 414-0396

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your protected health information (PHI). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2007 and will remain in effect until we replace it.

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Understanding what is in your medical record and how your health information is used helps you to better understand who, what, when, where and why others may access your health information and make better informed decisions when authorizing disclosures to others.

HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED:

Treatment: Atlas Chiropractic of Syracuse P.L.L.C. may use and disclose your health information to a physician or other healthcare providers who are involved in taking care of you. For example, we may disclose information to other facilities when scheduling other medical appointments, setting up an MRI, X-rays, etc...

Payment: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: In order for Atlas Chiropractic of Syracuse P.L.L.C. to operate in accordance with applicable law and insurance requirements and in order for the practice to continue to provide quality and efficient care, it may be necessary for us to compile, use and/or disclose you PHI in order to evaluate the performance of our personnel in providing care to you.

Appointment Reminders: Atlas Chiropractic of Syracuse P.L.L.C. may contact you to remind you that you have an appointment or need a referral for an appointment. This may be left on your answering machine, voice mail, postcard, etc., unless you inform us otherwise.

Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may also revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family/Friends: Atlas Chiropractic of Syracuse P.L.L.C may disclose your health information to your family member, other relative or a close personal friend, or any other person identified by you, but only if you agree that we may do so.

Individuals Involved In Your Care Or Payment For Your Care: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care, but only if you agree that we may do so. We will only disclose the health information directly relevant to their involvement in your care.

Marketing: Atlas Chiropractic of Syracuse P.L.L.C. will not use and/or disclose your health information for marketing activities without your written authorization.

Required By Law: Atlas Chiropractic of Syracuse P.L.L.C. may use or disclose your health information, when required by federal,

state, or local law.

Neglect Or Domestic Abuse: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information to appropriate authorities, if we reasonable believe that you are a possible victim of abuse, neglect or domestic abuse, without *Workers Compensations*: Atlas Chiropractic of Syracuse P.L.L.C. may disclose your health information as authorized to comply with worker's compensation laws.

Law Enforcement: Atlas Chiropractic of Syracuse P.L.L.C. may release your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons of similar process subject to all applicable legal requirements.

YOUR HEALTH INFORMATION RIGHTS

You Have The Right To Inspect And Maintain A Copy Of Your Protected Health Information: You may inspect and maintain a copy of your medical and billing records. A reasonable copying charge may apply.

You Have the Right to Request Restriction of Your Health Information: You may ask us to restrict or limit disclosure of your health information; however, we are not required to agree to these restrictions. If the chiropractor believes it is in your best interest to permit use and disclosure of you information, it will not be restricted. If the chiropractor does agree to these restrictions, we will abide by our agreement (except in an emergency).

You Have The Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location: You may make this request in writing to our practice's privacy officer and your request must specify the alternate means of location you request.

You Have The Right To Receive An Accounting Of Disclosures Of Your Health Information: You have the right to receive a list of instances in which Atlas Chiropractic of Syracuse P.L.L.C. disclosed your health information other than treatment, payment or healthcare operation or for disclosures that occurred prior to June 1, 2007. You must submit a written request to the contact officer and must include a time frame, which may not be longer than seven years or may not include dates prior to June 1, 2007.

You Have The Right To Request That We Amend Your Health Information: To request an amendment, you must submit your request in writing to our practice's privacy officer and provide a reason that supports your request. Atlas Chiropractic of Syracuse P.L.L.C. may deny your request under certain circumstances.

You Have the Right To Register A Complaint If You Feel Your Privacy Rights Have Been Violated: If you believe your privacy rights have been violated you may file a complaint with our practice's privacy officer. You must also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

We reserve the right to change our privacy practices and applicable law permits the terms of his notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Atlas Chiropractic of Syracuse P.L.L.C.
141 Shop City Plaza, Syracuse, NY 13206

Phone: (315) 414-0224
Fax: (315) 414- 0396

____ I acknowledge that I have read and understand this privacy notice. ____ I would like a copy of this privacy notice

_____ _____

Print Name Patient's Signature Date

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score

PATIENT HISTORY UPDATE

Name_____SSN_____ Signature_____Date_____

In order for us to better serve you; we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your own health! Thank you.

Please list and describe your symptoms, problem, condition, diagnosis or other factor that is the reason for your visit to this clinic today.

Are your symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □YES□ NO *If you answered yes, please fill out accident specific form, available at the front desk.*

Please describe in detail how your present illness/symptoms developed/started (suddenly or gradually) from first sign and/or symptom to the present (including location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms, etc.)

Describe the quality/character of your symptom(s).Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity? *Please circle.*

What is your pain/discomfort like today?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain
What is your least pain/discomfort?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain
What is your worst pain/discomfort?	No Pain	0 -1 -2 -3 -4 -5 -6 -7 -8 -9 -10	Severe Pain

How much time during an average day are you in pain/discomfort?
□ Less than 1 hour per day □ Between 1 and 4 hours per day □Almost anytime when not lying down
□Almost 24 hours per day □ Between 4 and 8 hours per day □Other

What made your symptoms better or worse?

Is your sleep disturbed by these symptoms? □ YES □ NO □ Slightly □ Moderately □ Severely

Have you experienced any restrictions or difficulties in any ACTIVITIES OF DAILY LIVING, SOCAIL and RECREATIONAL ACTIVITIES because of your current condition, please describe in detail (such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving etc) □ YES □ NO □ Slightly □ Moderately □ Severely

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic? □ YES □NO
If yes please list each doctor individually.

How much were your symptoms/discomforts improved or helped? *Please circle.*
No improvement 0---1 ---2 ---3 ---4 ---5 ---6 --- 7---8 --- 9--- 10 Full improvement

Since your symptoms began, were they □ Improved □ Worsened □Stayed the same?

Who is filling out this questionnaire? □Self □ Spouse □ Other

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's signature_____ Date: _____

Physicians signature_____ Date: _____

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

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR 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 A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

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

13. IF YOUR 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 TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____

AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

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:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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 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.

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. YOUR 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).

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