MUNROE CHIROPRACTIC

6035 Main Street | Williamsville, NY 14221
P: 716-632-4476 | F: 716-632-4503

Today's date:

Office use Only
☐ Cash ☐ NF
☐ WC ☐ Med.

HEALTH QUESTIONNAIRE

In order to save time, and better serve you, please complete all questions.

Name: *(First)* _____ *(M)* _____ *(Last)* _____

Date of Birth:_____ Gender: _____ Sex at birth: ☐ M ☐ F *Preferred name*:_____

Address:_____ City:_____ State:_____ Zip:_____

Home#:_____ Cell#:_____ Work #:_____ Preferred #: H C W

Email Address: _____ **Relationship Status:** _____

Employment Status: ☐ Part Time ☐ Full Time ☐ Disabled ☐ Retired ☐ Not Employed

Occupation:_____ Employer:_____

Employers Address_____

Student Status: ☐ Part Time ☐ Full Time School:_____

Do you have Medicare as your primary insurance? Yes No If yes, what is your Medicare ID number: _____

Primary Care Physician *(Name, Address, and telephone number)*:_____

_____

Whom may we thank for referring you to our office?_____

Who can we contact in case of an emergency?_____ Phone#:_____

Main Complaint: Why are you here today? Be specific with location:_____

_____

Are today's complaints the result of (Please check 'Yes' or 'No'): A. Worker's Compensation Injury? [ ] Yes [No

B. Auto (No Fault) Accident? [ ] Yes [ ] No C. Home Injury? [ ] Yes [ ] No

Date complaints started:_____ 2. Did it begin gradually or suddenly?_____

How did it start? Explain:_____

Rate the severity of your pain: (0 = No Pain to 10 = Excruciating) (Please Circle) 1 2 3 4 5 6 7 8 9 10

Frequency of symptoms: [ ]Constant (75-100%) [ ] Frequent (50-75%) [ ] Occasional (25-50%) [ ] Intermittent (10-25%) [ ]Rare

Describe your pain: [ ]Aching [ ]Gripping [ ]Pressure [ ] Sharp [ ]Shooting [ ] Soreness [ ]Stiffness Other:_____

Does it radiate to any other part of your body? Yes No Where?_____

If yes, are you experiencing: [ ] Numbness [ ] Tingling [ ] Weakness

What makes your symptoms better?_____

What makes your symptoms worse?_____

Time of day symptoms are worst: [ ] Morning [ ] Afternoon [ ]Evening [ ]After work [ ] Middle of night Other:_____

Doctor's Initials:_____

Name:_____ Date:_____

Does your condition interfere with: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation [ ] Chores [ ] Child/Pet care

Activities hindered: [ ] Bending [ ]Driving [ ]Laying down [ ]Lifting [ ] Typing [ ] Walking

Have you tried home remedies? Yes No What?_____

What doctors have you seen and what tests have been done for your condition?_____

Have you had anything like this before? Yes No Details:_____

Has your problem been getting BETTER, WORSE, or STAYING about the SAME?_____

Have you been unable to work as a result of your current problem? [ ] Yes [ ] No

Do you have any other problems that you would like the doctors to evaluate?_____

Past History:

Have you had any of the following childhood diseases: [ ] Measles [ ] Rubella [ ] Chickenpox [ ] Mumps

[ ] Scarlet Fever [ ] Rheumatic Fever [ ] Tuberculosis [ ] Other?:_____

Any fever, unexplained weight loss/gain or changes in bowel or bladder functions: [ ] Yes [ ] No

Have you been diagnosed with any other conditions? Yes No Explain:_____

Are you under a doctor's care presently for any type of health problem?_____

Have you had any broken bones? Yes No Which ones?_____

Have you ever had any whiplash, auto accidents, work injuries, home injuries or falls?[ ]Yes [ ] No When?_____

Have you undergone any type of surgery? Yes No What and when?_____

Do you eat regular meals? Yes No How many meals per day? _____ Snacks per day?_____

How often do you exercise?_____

Do you take vitamins or nutritional supplements?_____

How many hours per night do you usually sleep? _____ How do you sleep? On your: [ ] Back [ ] Side [ ] Stomach

Do you wear: [ ] Heel Lifts [ ] Shoe Lifts [ ] Arch Supports [ ] Orthotics

Do you drink alcohol, caffeine or use recreational drugs?_____

Do any diseases run in your blood relatives?_____ Any relatives suffer a stroke?:_____

Do you have any allergies?_____

Are you taking any medication? Yes No If yes please list with Dose amount and response to medication

_____

Do you currently smoke? [ ]Yes [ ] No Have you smoked in the past? [ ]Yes [ ] No

Have you had any of these following symptoms for even a short or temporary duration?

Sudden collapse without loss of consciousness [ ] YES [ ] NO

Diminished or partial loss of vision in 1 or both eyes [ ] YES [ ] NO

Numbness of loss of sensation in the face, arms, hands, fingers, and/or legs [ ] YES [ ] NO

Weakness, clumsiness, or strength loss in the face, arms, hands, fingers, and/or legs [ ] YES [ ] NO

Any other abnormal or loss in any other part of your body [ ] YES [ ] NO

Loss of consciousness, even momentary blackouts [ ] YES [ ] NO

Doctor's Initials:_____

Name:_____ Date:_____

Symptoms

General:

- ☐ Bruise easily
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Lack of Understanding
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Heart or blood vessel disease
- ☐ Bone spurs on neck
- ☐ Hardening of the arteries
- ☐ Slurred speech or other speech problems

Gastrointestinal:

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel/Bladder changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular:

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat:

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Vision- Flashes
- ☐ Vision- Halos

Men:

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Difficulty with urination
- ☐ Excessive Urination
- ☐ Other: _____

Date of last prostate exam:_____

Women:

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other:_____

Date of last menstrual period:_____

Date of last pap smear: _____

Have you had a mammogram? _____

Do you take birth control pills?_____

If yes, for how long?_____

Are you pregnant?_____

Number of children:_____

Attention: Payment is to be made at the time of the visit unless prior arrangements have been made with this office. By signing below, you grant consent to any procedures or treatments necessary for treatment of any condition as deemed reasonable by the attending doctor.

Patient Signature: _____ Date:_____

Office use only:

Acct# _____ *XR#*_____ *XR views*_____

CA who entered pt in CT: _____ *Video shown by:* _____ *One on given by:* _____

Doctors initials:_____

MUNROE CHIROPRACTIC PATIENT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to that information. Please review this notice carefully.

Munroe Chiropractic is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from our office. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

MUNROE CHIROPRACTIC MAY USE AND/OR DISCLOSE YOUR PHI FOR THE FOLLOWING REASONS:

- **Treatment**: In order to provide you with the healthcare you require our office will provide your PHI to those health care professionals, whether on our staff or not, directly involved in your care so that they may understand your health condition and needs.
- **Payment:** In order to get paid for services provided to you we will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
- **Health Care Operations:** In order for our office to operate in accordance with applicable law and insurance requirements and in order for the office to continue to provide quality and efficient care, it may be necessary for us to compile, use and/or disclose your PHI.

Munroe Chiropractic may also use and /or disclose your PHI without your specific authorization in the following additional instances: De-Identified Information Business Associate / Personal Representative Emergency Situations / Public Health Activities Abuse, Neglect or Domestic Violence / Health Oversight Activities Judicial and Administrative Proceedings / Law Enforcement Purposes / Coroner or Medical Examiners / Sign-In Sheet Referral Board / Avert a Threat to Health or Safety / Specialized Government Functions / Workers' Compensation National Security and Intelligence Activities / Military and Veterans Family Member or any other person identified by you

Munroe Chiropractic's additional uses of your information:
New Patient Letter Telephone Messages / Personal Acknowledgement Cards / Appointment Reminder Cards

Uses and/or disclosures, other than those listed above will be made only with your written authorization.

YOUR RIGHTS: You have the right to...

- Revoke any authorization in writing, at any time.
- The right to request restrictions on the use and disclosure of your Protected Health Information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your Protected Health Information
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting of how and to whom your Protected Health Information has been disclosed.
- The right to receive a printed copy of this notice.
- Complain to Munroe Chiropractic or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.
- To obtain more information on or have your questions about your rights answered, you may contact Marianne Millidge at 632-4476 or via e-mail at marianne @munroechiropractic.com

MUNROE CHIROPRACTIC'S REQUIREMENTS:

- We are required by Federal Law to maintain the privacy of your PHI and to provide you with this privacy notice.
- We are required by New York State Law to maintain a higher level of confidentiality with respect to certain portions of your medical information than is provided under Federal Law. The particular state statutes are posted in our reception area.
- We are required to abide by the requirements of this privacy notice.
- We reserve the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for all of your PHI that it maintains.
- We will distribute any revised privacy notice to you prior to implementation.
- We will not retaliate against you for filing a complaint.

THIS NOTICE IS IN EFFECT AS OF APRIL 14, 2003.

Munroe Chiropractic, PC
6035 Main Street
Williamsville, NY, 14221
Phone 716-632-4476 Fax 716-632-4503

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language I can understand.

_____ _____

Name of Individual

Signature of Individual

_____ _____

Signature of Legal Representative

Relationship
(e.g, Attorney-In-Fact, Guardian, Parent if a minor)

Date signed:_____

Witness:_____

MUNROE CHIROPRACTIC, PC
6035 MAIN STREET
WILLIAMSVILLE, NY 14221
Phone: 716-632-4476 – Fax: 716-632-4503

AUTO RELATED ACCIDENT INFORMATION

Name:_____ Date:_____

Date and time of accident: _____, _____ a.m. or _____ p.m.

Were you one of the following (Please check one): [ ] Driver [ ] Front passenger [ ] Rear passenger

Number of people in the vehicle: _____

If a violation was issued, to whom was it issued?_____

Did the police come to the accident site?_____ Was a police report filed? _____

Were you wearing a seat belt? [ ] Yes [ ] No

Was this vehicle equipped with airbags? [ ] Yes [ ] No

If yes, did it/they inflate? [ ] Yes [ ] No

In relation to the base of your skull, where was the headrest? [ ] Above [ ] Below [ ] At base of skull

What did your vehicle irnpact? [ ] Another vehicle [ ] Other:_____

If other, explain:_____

Did any part of your body strike anything in the vehicle? [ ] Yes [ ] No

If yes, please describe:_____

What was the make and model of the vehicle you were occupying?_____

Name of the location/street on which you were traveling:_____

What was the approx. speed of your vehicle?_____

Did the impact to your vehicle come from the: [ ] Front [ ]Rear [ ]Right Side [ ] Left Side [ ] Other

During impact, were you facing: [ ] Right [ ] Left [ ] Forward

Were you aware or surprised by the impact?_____

If your vehicle made impact with another vehicle, what was the make and model of that other vehicle?

_____

Direction other vehicle was headed? [ ] North [ ] South [ ] East [ ] West

What was the speed of the other vehicle?_____

At the time of the accident were you working? [ ] Yes [ ] No

At the time of the accident were you in a taxi or rideshare? [ ] Yes [ ] No

At the time of the accident were you in a rental car? [ ] Yes [ ] No

Name:_____ Date:_____

In your own words, please describe the accident:_____

_____

_____

Did the accident render you unconscious? [ ]Yes [ ] No If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

_____

Have you gone to a hospital or seen any other doctor? [ ] Yes [ ] No

When did you go? [ ] Right after the accident [ ] The next day [ ] 2 or more days later

How did you get there? [ ] Ambulance [ ] Private transportation

Please provide, the name of hospital and /or attending doctor and the treatment given:_____

_____

Were X-rays taken? [ ]Yes [ ] No If yes, what part of your body?_____

Have you been able to work since the accident? [ ]Yes [ ] No

Are your work activities restricted as a result of this injury? [ ]Yes [ ] No

Please indicate the symptoms that are a result of this accident:

[ ] Dizziness	[ ] Difficulty Sleeping	[ ] Jaw Problems	[ ] Nausea
[ ] Memory Loss	[ ] Irritability	[ ] Arm/Shoulder pain	[ ] Back Pain
[ ] Headache(s)	[ ] Fatigue	[ ] Numb hands/fingers	[ ] Low Back Pain
[ ] Blurred Vision	[ ] Tension	[ ] Chest Pain	[ ] Back Stiffness
[ ] Buzzing in Ear	[ ] Neck Pain	[ ] Shortness in Breath	[ ] Leg Pain
[ ] Ears Ringing	[ ] Neck Stiff	[ ] Stomach Upset	[ ] Numb Feet/Toes

[ ] Other:_____

Is your condition getting worse? [ ]Yes [ ] No Is it? [ ] Constant [ ] Comes and goes

Indicate your ***degree of comfort*** while performing the following activities:

Lying on Back	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Lying on Side	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Lying on Stomach	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sitting	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Standing	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Stretching	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sexual Intercourse	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Walking / Running	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Sports	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Working	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Lifting	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Bending	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful

Name:_____ Date:_____

Kneeling	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Pulling	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful
Reaching	[ ] Comfortable	[ ] Uncomfortable	[ ] Painful

Employer:_____ Employer's Phone #:_____

Employer's Address:_____

Have you retained an attorney? [ ]Yes [ ] No

If yes, please provide name and phone number: _____

Do you have any congenital (from birth) factors which relate to this problem? [ ]Yes [ ] No

If yes, please describe:_____

Do you have any previous illnesses which relate to this case? [ ]Yes [ ] No

If yes, please describe:_____

Have you ever been involved in an accident before? [ ]Yes [ ] No

If yes, please describe:_____

To evaluate the effect that continuing work will have on your recovery, please complete the following:

How many hours are in your normal work day?_____

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

[ ] Standing	[ ] Driving	[ ] Operate equipment
[ ] Sitting	[ ] Twisting	[ ] Work with arms above head
[ ] Walking	[ ] Crawling	[ ] Typing
[ ] Lifting	[ ] Bending	[ ] Stooping

Do you work with others who can help you with any heavy lifting?[ ]Yes [ ] No

While in recovery, is there any light duty work you could request?[ ]Yes [ ] No

YOU CANNOT TREAT WITH A MESSAGE THERAPIST, ACUPUNCTURIST OR PHYSICAL THERAPIST ON THE SAME DAY AS YOUR CHIROPRACTIC TREATMENT-even if it's for different body parts. Your insurance company will not pay for both, so please keep this in mind when scheduling your appointments

PATIENT SIGNATURE:_____

DATE:_____ DOCTOR REVIEWED/INITIALS:_____

MUNROE CHIROPRACTIC, PC

6035 MAIN STREET
WILLIAMSVILLE, NY 14221
Phone: 716-632-4476 - Fax: 716-632-4503

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any other medical facility, insurance company, attorney or adjuster in order to process any claim for charges incurred by me as a result of professional services rendered by you. I also hereby release you of any consequences thereof.

ASSIGNMENT OF PAYMENT

My insurance company and or attorney are hereby requested to pay direct to MUNROE CHIROPRACTIC P.C. any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amount of charges and the amount paid him by the insurance company and or attorney. It is further understood that I, the undersigned agree to pay the full amount of his charge, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay the claim or pays me directly.

THE PATIENT IS RESPONSIBLE FOR ALL THEIR EXPENSES INCURRED AT THIS OFFICE.

Patient's Signature:_____

Witness's:_____

Date:_____

Dedicated 7 Days A Week For You

MUNROE CHIROPRACTIC, PC

6035 Main Street, Williamsville, NY 14221
Phone: 716-632-4476 | Fax: 716-632-4503

AUTHORIZATION TO PAY BENEFITS

NEW YORK STATE MOTOR VEHICLE NO-FAULT INSURANCE LAW

I authorize payment of health benefits to the undersigned health care provider or supplier of services described below. I retain all rights, privileges and remedies to which I am entitled under Article 51 (the No-Fault provision) of the Insurance Law.

Patient Name	Patient Signature	Date

Provider of Health Care Service Name	Provider of Health Care Service Signature	Date

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.

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

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.

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, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	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)? YES ☐ NO ☐	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

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