AUTOMOBILE ACCIDENT QUESTIONNAIRE

-PLEASE ANSWER ALL QUESTIONS COMPLETELY-

PATIENT INFORMATION: **DATE:** _____

Name: _____ SS#: _____

Sex: Male / Female E-mail address: _____

Marital Status: S M D W Are you a minor?: Y / N

Birth Date: _____ / _____ / _____ Age: _____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

EMPLOYMENT INFORMATION:

Employer / Business Name: _____

Phone #: ( ) _____ EXT: _____

Address: _____

Job Title: _____

INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Name of policyholder: _____

Relationship to Patient: _____

ATTORNEY INFORMATION:

Attorney Name: _____ Phone #: ( ) _____

Address: _____

How were you referred to our office? _____

VEHICLE ACCIDENT REPORT

Name _____

1. Date of Accident ____ / ____ / ____ 2. Time of Accident ____:____ (AM / PM)
3. Were you: **A)** Driver **B)** Passenger (Front) **C)** Passenger (Rear) **D)** Pedestrian
4. Were you wearing seatbelts? ___ Yes ___ No
5. Type of vehicle: **A)** Auto **B)** Truck **C)** Van **D)** Motorcycle **E)** Motor home **F)** Bicycle
6. How accident occurred: **A)** Struck by another vehicle **B)** Struck another vehicle **C)** Struck a stationary object **D)** Other
7. Where was your vehicle hit? **A)** Front **B)** Rear **C)** Rt. Side **D)** Lft. Side **E)** Rt. Front **F)** Lft. Front **G)** Rt. Rear **H)** Lft. Rear
8. Where was other vehicle hit? **A)** Front **B)** Rear **C)** Rt. Side **D)** Lft. Side **E)** Rt. Front **F)** Lft. Front **G)** Rt. Rear **H)** Lft. Rear
9. Your approximate speed _____ MPH 10) Other vehicle approximate speed _____ MPH
11. What occurred at the moment of impact? (Circle as many as apply)
    A) Tensed body for impact **B)** Neck whipped forward & back **C)** Spine torqued and twisted **D)** Thrown over seat
    E) Thrown from vehicle **F)** Pinned in vehicle **G)** Thrown from side to side **H)** Cut and bruised
12. Did you strike your: (Circle as many as apply)

A. Head		Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
B. Shoulder	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
C. Arm	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
D. Elbow	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
E. Wrist	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
F. Hip	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
G. Knee	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object
H. Ankle	Lft / Rt	Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Rt. Door 5) Lft. Door 6) Seat Frame 7) Unknown Object

13. Were you rendered unconscious? (Y / N) 14. Did you receive medical attention at the scene of the accident? (Y / N)
15. Where did you go immediately following the accident? **A)** Hospital **B)** Home **C)** Personal Doctor **D)** To this office **E)** Resumed Activities
16. Were you: (Circle as many as apply) **A)** Shaken **B)** Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe _____

_____

_____

In your own words, please describe the accident _____

_____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

_____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.

Past History:

1. Have you ever injured this area before? _____ If yes, when? _____
2. If injured before, did you lose time from work? _____
3. If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted
   _____
4. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation? ____ If yes, please explain dates and details _____
   _____
   _____
5. Have you been treated previously by a chiropractor? ____ If yes, please explain _____
   _____

Present Information/Disability:

1. Have you returned to work? ____ If yes, date returned to work _____
2. Job description _____
3. Do you have to favor any part of your body in your work? ____ If yes, please explain
   _____
4. Are your work activities restricted as a result of this accident? ____ If yes, please explain
   _____
5. Since this injury, are your symptoms: improving ____, getting worse ____ or the same ____ ? Please explain _____
6. Do any other diseases or accidents affect your employment? ____ If yes, please explain
   _____

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 Signature Date

_____ _____
Doctor's Signature (upon review) Date

HEALTH QUESTIONNAIRE

PLEASE CHECK ALL THAT APPLY:

MUSCULO SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Rupture
___ Broken bones

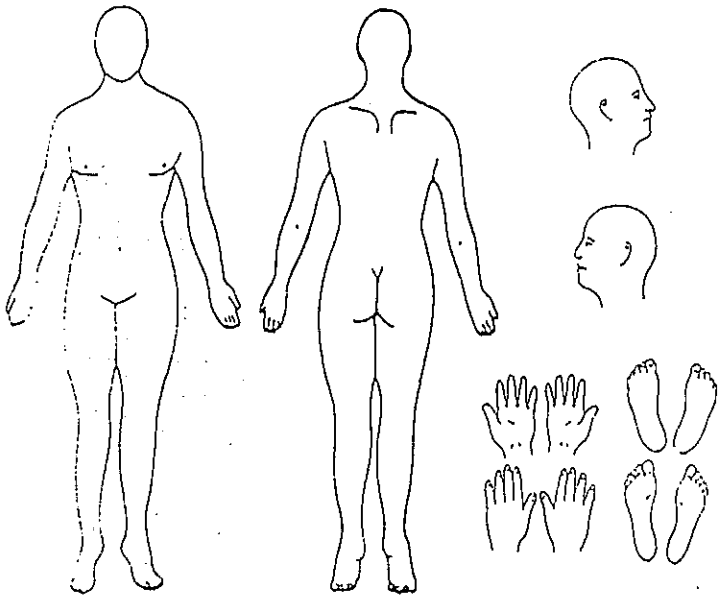
GENITO-URINARY SYSTEM

___ Bladder trouble
___ Excessive urination
___ Scanty urination
___ Painful urination
___ Discolored urine

FEMALE

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Are you pregnant?
___ Yes ___ No



GASTRO-INTESTINAL SYSTEM

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

CARDIO VASCULAR RESPIRATORY SYSTEM

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

EYES, EAR, NOSE AND THROAT

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficulty breathing thru nose
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

_____
Patient's Signature

**********DO NOT WRITE BELOW THIS LINE**********

Patient Accepted? Yes No Doctor's Signature _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize (name of provider) _____

(2) To discuss the following information from the health records of:

Patient name: _____ Date of birth: _____

Address: _____ Telephone: _____

_____ Medical Record Number: _____

Dates of Service: post MVA on

(3) Information to be disclosed:

(A) ☐ complete health record(s) ☑ discharge summary ☐ billing records
☑ history & physical ☑ progress notes
☑ x-ray reports ☑ laboratory tests
☐ other (please specify) _____

(B) I understand that this will include information relating to (check if applicable): *(If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.)*

☐ acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
☐ behavioral health services/psychiatric care
☐ treatment for alcohol and/or drug abuse
☐ domestic abuse Initials: _____

(4) At the request of the patient, this information is to be released to: South Shore Chiropractic, PC
700 Horseblock Rd.
Farmingville, NY 11738

for the purpose of: Treatment

(5) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I understand that signing this authorization is voluntary. I also understand I may refuse to sign this form and that my health care and payment will not be affected.

Date: _____ Initials: _____

(6) The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for the above disclosure of the above information to the extent indicated and authorized herein.

(7) I may request a copy of this form after signing.

(8) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in 3 B) and this re-disclosure may no longer be protected by federal or state law.

Initials: _____

Signed: _____
(patient) (this form to be completed before signing) (date)

_____
(legal representative) (relationship to patient – description of authority) (date)

_____
(signature of witness) (relationship to patient) (date)

Note: Release of all confidential information is governed by State and Federal and HIPAA Regulations.
06/04/04

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** South Shore Chiropractic, P.C., **("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)**

South Shore Chiropractic _____
700 Horseblock Rd. (Date of signature)
Farmingville, NY 11738
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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

Date	Policyholder	Policy Number	Accident Date	File Number

Claimant

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 ALSO SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

1. YOUR NAME	2. TELEPHONE NUMBERS HOME	BUSINESS

3. YOUR ADDRESS (NO. STREET, CITY OR TOWN, AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NUMBER

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

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

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

14. AMOUNT OF HEALTH BILLS TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENT?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ unknown	☒ YES ☐ NO	☐ YES ☒ NO

A3538307

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

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 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 ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AN 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
WORKMEN'S COMPENSATION? ☐ YES ☐ NO

THE APPLICATION 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 APPLICATION 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 FOR 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 ANY 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 STATE CLAIM FOR EACH VIOLATION.

SIGNATURE: DATE:

IMPORTANT NOTICE:
YOU MUST SIGN, COMPLETE AND RETURN THE ENCLOSED AUTHORIZATION FORMS WITH THIS COMPLETED APPLICATION FOR NO-FAULT BENEFITS.

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

This authorization or photocopy hereof, 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 _____

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-RAY 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.)

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