

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Patient Name: _____

Today's Date: _____

Date of Birth: _____

Home Phone: _____

Home Address: _____

ACCIDENT INFORMATION

Date of Accident: _____

Accident Location: _____

Insurance Company: _____

Claim # _____

Ins. Co. Address: _____

City, State, Zip _____

Ins. Co. Phone: _____

Ins. Co. Fax: _____

Insurance Adjuster: _____

Name of Policy Holder: _____

Relationship to Policy Holder: _____

Were the Police Notified? *yes* *no*

Did you report your accident to your insurance company? *yes* *no*

Did you submit the "Application of No Fault Benefits" to your insurance company? *yes* *no*

If "yes", date? _____

If "no" please notify our office immediately

When did your present symptoms appear? _____

Have you ever had any complaints in the area involved before? *yes* *no*

If "yes", please explain: _____

Since the accident, are your symptoms: Improving Getting Worse Same

Have you retained an attorney? *yes* *no*

If "yes", name of Attorney: _____

Attorney Address: _____

Attorney Phone: _____

Attorney Fax: _____

Have you lost time from work? *yes* *no*

If so, how long? From: _____ Date to: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for No Fault is denied. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Patient's 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 Jeffrey J. Cianchetti, D.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)

Jeffrey J. Cianchetti, D.C.
(Print name of Provider)

(Signature of Provider)

2119 Sawyer Drive

(Date of signature)

Niagara Falls, NY 14304
(Address of Provider)