MOTOR VEHICLE/NO-FAULT INTAKE FORM

Name (PLEASE PRINT) _____ Date of Birth _____

CARRIER INFORMATION

Insurance Carrier Name: _____ Carrier Phone No. _____

Address: _____

Policy No. _____ Claim No. _____ Date of Accident: _____

INJURY INFORMATION

Was the accident reported to your carrier? ❒ yes ❒ no

Have you filed an application for no-fault benefits with the carrier? ❒ yes ❒ no

Were you the driver of the vehicle or a passenger? _____

How did the accident happen? _____

_____

Have you lost time from work? ❒ yes ❒ no If yes, how much? _____

Have you seen another physician for this condition? ❒ yes ❒ no Doctor's Name: _____

Were x-rays taken? ❒ yes ❒ no Other tests? ❒ yes ❒ no If yes, please list test and facility where taken: _____

ATTORNEY INFORMATION

Attorney's Name: _____ Phone No. _____

Address: _____

May we contact your attorney regarding your case? ❒ yes ❒ no

AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment in the event that my claim for No-Fault benefits are denied.

Patient's Signature: _____ Date: _____

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.

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