PATIENT REGISTRATION
MOTOR VEHICLE ACCIDENT / NO FAULT

Today's Date:

PATIENT INFORMATION

Name:

Name Preferred to Be Called:

Date of Birth:

Social Security #:

Mailing Address:

City, State, Zip:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone #:

Cell Phone #:

Work Phone #: Ext:

Email Address:

Referred To Us By:

PRIMARY CARE PHYSICIAN

Primary Care Physician:

Street Address:

City, State, Zip:

Clinic Name:

Phone #:

Fax #:

NO-FAULT INSURANCE INFORMATION

Date of Injury:

Injured Areas of the Body:

No Fault Insurance Carrier:

Insured's Name:

Policy #:

Claim #:

Examiner's Name:

Examiner's Phone #: Ext:

Examiner's Fax #:

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance:

Policy Holder:

Policy Holder's Birthday:

Policy #:

ATTORNEY INFORMATION

Attorney Name:

Attorney Address:

City, State, Zip:

Attorney Phone #: Fax #:

IN CASE OF EMERGENCY

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

Assignment & Release *- By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Patient / Guardian Date

Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918
Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840

PATIENT HEALTH HISTORY

If you are presently troubled by a particular condition or have ever had a listed condition in the past, please check it in the Yes column. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent

Yes	No		Yes	No	
___	___	Neck Pain (723.1)	___	___	Aortic Aneurysm (441.5)
___	___	Shoulder Pain (719.41)	___	___	High Blood Pressure (401.9)
___	___	Pain in ☐ Upper Arm or ☐ Elbow (719.42)	___	___	Angina (413.9)
___	___	Hand Pain (719.44)	___	___	Heart Attack (411.0)
___	___	Wrist Pain (719.43)	___	___	Stroke (436.9)
___	___	Upper Back Pain (724.1)	___	___	Asthma (439.9)
___	___	Low Back Pain (724.2)	___	___	Cancer ☐ Past (V10) ☐ Present (199.1)
___	___	Pain in ☐ Upper Leg or ☐ Hip (719.45)	___	___	Tumor (229.9)
___	___	Pain in ☐ Lower Leg or ☐ Knee (729.5)	___	___	Prostate Problems (601.9)
___	___	Pain in ☐ Ankle or ☐ Foot (719.47)	___	___	Blood Disorder (790.6)
___	___	Jaw Pain (526.9)	___	___	Emphysema (Chronic Lung Disorders) (492.8)
___	___	Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5)	___	___	Arthritis (716.9)
___	___	Fainting (780.2)	___	___	Rheumatoid Arthritis (714.0)
___	___	Visual Disturbances (728.9)	___	___	Diabetes ☐ Type I (250.01) ☐ Type II (250.00)
___	___	Convulsions (780.3)	___	___	Epilepsy (349.5)
___	___	Dizziness (780.4)	___	___	Ulcer (556.9)
___	___	Headache (784.0)	___	___	☐ Liver (573.9) / ☐ Gallbladder Problems (575.9)
___	___	Muscular Incoordination (781.3)	___	___	Kidney Stones (592.0)
___	___	Tinnitus (Ear Noises) (388.30)	___	___	Hepatitis (573.3)
___	___	Rapid Heart Beat (785.0)	___	___	Bladder Infection (595.9)
___	___	Chest Pain (786.50)	___	___	Kidney Disorders (V11.03)
___	___	Loss of Appetite (783.0)	___	___	Colitis (558.9)
___	___	Irritable Colon (564.1)	___	___	Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2)
___	___	Excessive Thirst (783.5)	___	___	HIV (V08) /AIDS (042)
___	___	Chronic Cough (786.2)	___	___	Anorexia (307.1)
___	___	Chronic Sinusitis (473.9)	___	___	Systemic Lupus (710.0)
___	___	General Fatigue (780.7)	___	___	Other _____
___	___	Irregular Menstrual (626.4)			
___	___	Profuse Menstrual (611.72)	**Yes**	**No**	
___	___	Breast ☐ Soreness / ☐ Lumps (611.72)	___	___	Tobacco ☐ Present (305.1) ☐ Past (V15.82)
___	___	Endometriosis (617.9)	___	___	Alcohol If Yes, Frequency: _____
___	___	PMS (625.4)	___	___	☐ Drug / ☐ Alcohol Dependence (V11.3/303.99)
___	___	Loss of Bladder Control (788.30)	___	___	☐ Coffee / ☐ Tea / ☐ Caffeinated Soft Drinks
___	___	Painful Urination (788.1)			Servings per Day: _____
___	___	Frequent Urination (788.41)	___	___	Hospitalization / Surgeries: _____
___	___	Abdominal Pain (789.0)			_____
___	___	☐ Constipation / ☐ Irregular Bowel Habits (564.0)	___	___	Prior Accidents/Injuries: _____
___	___	Difficulty Swallowing (787.2)			_____
___	___	☐ Heartburn / ☐ Indigestion (787.1)	___	___	Current Medications (Rx, OTC, Vitamins):
___	___	☐ Dermatitis / ☐ Eczema / ☐ Rash (692.9)			_____
___	___	Depression (311.9)			_____

Yes	No	
___	___	Do You Have A Permanent Disability Rating?

Area of the Body Affected: _____

Date Rating Received: _____

Rating Percentage: _____

Please List Any Known Allergies: _____

_____

_____

Weight _____ lbs **Height** _____ Ft _____ In

Immediate Family Medical History

___ Cancer (V16)	___ Chronic Back Problems (V17.89)
___ Heart Problems (V17.4)	___ Chronic Headaches (V19.8)
___ Lung Problems (V17.6)	___ High Blood Pressure (V17.49)
___ Diabetes (V18.0)	___ Rheumatoid Arthritis (V17.7)
___ Epilepsy (V17.2)	___ Other Condition(s): _____
___ Lupus (V19.8)	_____

For Women

Yes	No	
___	___	Are You On Any Form Of Birth Control?
___	___	Are You Nursing?
___	___	Are You Or Could You Be Pregnant?
		If Yes, How Far Along? _____
		If No, Last Period? _____

_____ _____

Patient Signature Date

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PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____

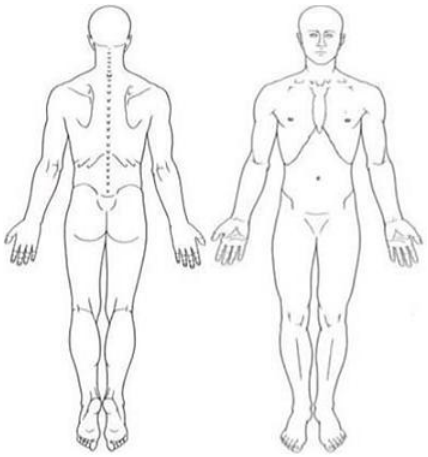
1. What is the reason for your visit today? _____

a. Approximately when did this current episode start? _____

b. What brought on this current episode? _____

c. Is this episode a worsening of a prior injury? ○ No ○ Yes, it was: ○Work-related ○Auto Accident ○Other

2. Location: Where does it hurt?



3. Nature of Symptoms

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ _____
- ○ _____

4. Intensity of Symptoms:

	None					Mild		Moderate			Severe
Currently:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
At its worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
At its best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

5. Duration: How often do you experience symptoms?

- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (56-50% of the day)
- ○ Intermittently (0-25% of the day)

6. Aggravating or Relieving Factors:

What makes your symptoms worse? _____

What makes your symptoms better? _____

7. Prior Treatment: What have you done to relieve the symptoms?

○ Chiropractic	○ Acupuncture	○ Prescription Meds: _____
○ Physical Therapy	○ Massage	○ Over-the-Counter Meds: _____
○ Surgery	○ _____	○ Homeopathic Remedies: _____

8. Activities of Daily Living: How much does this condition interfere with your life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting	○	○	○	○	Using a computer	○	○	○	○
Rising out of chair	○	○	○	○	Getting in/out of car	○	○	○	○
Standing	○	○	○	○	Driving/Riding in a car	○	○	○	○
Walking	○	○	○	○	Looking over shoulder	○	○	○	○
Lying down	○	○	○	○	Exercising	○	○	○	○
Bending over	○	○	○	○	Caring for family	○	○	○	○
Climbing stairs	○	○	○	○	Showering or bathing	○	○	○	○
Lifting objects	○	○	○	○	Dressing myself	○	○	○	○
Reaching overhead	○	○	○	○	Social life	○	○	○	○
Shopping	○	○	○	○	Getting to sleep	○	○	○	○
Household chores	○	○	○	○	Staying asleep	○	○	○	○
Yard Work	○	○	○	○	Concentrating	○	○	○	○

9. What is your current work status?

○ Working – Full Duty	○ Unemployed.....last date worked _____/_____/_____
○ Working – Modified Duty	○ Retired.....last date worked _____/_____/_____

10. What is your current occupation?

○ Homemaker ○ Full-Time Student ○ Retired ○ _____

11. Current: Height ____ feet ____ inches **Weight** _____ pounds **Smoking Status:** _____

12. Additional Comments: _____

_____

Patient Signature _____ **Date** _____

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

DATE	POLICY HOLDER	POLICY NUMBER	**DATE OF ACCIDENT**	CLAIM NUMBER
		N/A		

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 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 ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS:

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

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

NAME AND ADDRESS 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 ADDRESS:

14. AMOUNT OF HEALTH BILLS TO DATE	15. WILL YOU HAVE MORE HEALTH TREATMENTS(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? ☐ 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

(Continued on next page)

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

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

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

NEW YORK STATE DISABILITY? ☐ YES ☐ NO

WORKERS' COMPENSATION? ☐ YES ☐ NO

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 INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, 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 STATED VALUE OF THE CLAIM FOR EACH SUCH 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. 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 _____

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).

• BRACKETED LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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** _____ **, ("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)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)