NO-FAULT REGISTRATION

Referring Physician:____________________________

Referring MD Phone #:______________________________

NAME (Last, First, MI)____ SEX M F
Date of Birth: ________________ Age:________ SS #:_______________ Occupation:_______________________
Street Address:______________________________________ City:_________________ State:_____ Zip:_________
Mail Address (If Different):_____________________________ City:_________________ State:_____ Zip:_____
Home #:____________________ Cell #:__________________ E-Mail:______________________ Marital Status:__
Present Employer:____ Work Phone ________________________
Work Address:______________________________________ **City:**_______________ **State:**____ **Zip:**_______

IS THIS A MANAGED CARE NO-FAULT POLICY? YES__________ NO__________
Date of Injury:________________ Date Symptoms Began:_________________ What body part?________________
Have you ever injured this body part before? YES__________ NO__________
Location of Accident:____
Holder of Insurance:
Name:____
Address:____
Insurance Company Name:____
Insurance Company Address:____
Insurance Company Phone #:____
File #:________________________ **Policy #:**____
Was the Accident reported to your Insurance Company: YES__________ NO__________
Did injury occur while working?: YES__________ NO__________
Were you hospitalized?: YES__________ NO__________
Name of Hospital:____
Address of Hospital:____
Dates of Hospitalization:____
Were you disabled by this accident?: YES__________ NO__________
Date disability began:____
Will an Attorney be contacting us?____
(SHOULD NO FAULT BE DENIED)
Commercial Insurance Co.: Name:____
Commercial Insurance Address:____
Subscriber Name:____
Subscribers Employer:____
Employers Address:____
Group #____ ID#:_________________________________
IN CASE OF EMERGENCY CONTACT: Name:________________________________ Relationship __________
Cell #:______________________ home # ______________________ work # _____________________

Note: In consideration of services rendered or to be rendered to the above named patient, I hereby authorize and assign payment directly to Dr.______________________ , provider of health services. I authorize the provider to release all medical information necessary to substantiate a claim. In the event that the provider does not receive payment from the insurance company, due to denial for any reason, I understand I am personally responsible for payment of the provider's charges. I also understand that if I have not yet met my deductible under no-fault, that I am responsible for payment of such deductible, under my policy coverage. In the event my account goes to Collection, I understand that I will be responsible for all collection fees including the cost of an attorney.

____ ____________________________________
SIGNATURE *DATE*

PLEASE SIGN THE ATTACHED FORM (NF3) Checked By:________________________ Date:_________________

Revised 5/13