

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