

# WC & NF Patient Intake Form

LAST NAME		FIRST NAME		MIDDLE INITIAL	EMAIL ADDRESS	
ADDRESS			SEX	DATE OF BIRTH		SOCIAL SECURITY #
CITY		STATE	ZIP CODE	PHONE NUMBER		ALT. PHONE NUMBER
REFERRING PROVIDER		ADDRESS			PHONE NUMBER	
EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT		Date Of Injury:	Time Of Injury:	Injury Address and State:
EMERGENCY CONTACT PHONE #	EMERGENCY EMAIL ADDRESS		/ /	: AM PM		
HOW DID INJURY/ACCIDENT OCCUR?						

Do you have a history of same or similar condition?  YES  NO

If YES, state when and describe:

Did injury occur during your employment?  YES (IF YES COMPLETE "A")  NO

Is your injury a result of an auto accident?  YES (IF YES COMPLETE "B")  NO

* Pharmacy Name	Pharmacy Address, City State, Zip	Pharmacy Phone # :
*		Pharmacy Fax # :

## SECTION "A" (Workers Compensation)

OCCUPATION	ENTER YOUR USUAL ACTIVITIES ON THE DAY OF INJURY?
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### ENTER EMPLOYER NAME WHEN INJURY OCCURRED

EMPLOYER NAME			
EMPLOYER ADDRESS			
CITY	STATE	ZIP CODE	EMPLOYER PHONE NUMBER
EMPLOYER CONTACT NAME AND PHONE NUMBER			

### ENTER WORKERS' COMPENSATION INSURANCE INFORMATION

INSURANCE NAME					
INSURANCE ADDRESS			CITY	STATE	ZIP
POLICY NUMBER	INSURANCE CASE NUMBER		WCB CASE NUMBER		
CLAIM ADJUSTER NAME			INSURANCE PHONE NUMBER		

## SECTION "B" (No-Fault)

### ENTER YOUR AUTO INSURANCE INFORMATION

INSURANCE NAME					
INSURANCE ADDRESS			CITY	STATE	ZIP
POLICY NUMBER	INSURANCE CLAIM NUMBER				
CLAIM ADJUSTER NAME			INSURANCE PHONE NUMBER		

\_\_\_\_\_  
Patient 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 \_\_\_\_\_, ("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)