

**VKPMedical, PLLC.**  
**920 Main Street, Niagara Falls, NY 14301**  
**5 Limestone Drive, Williamsville, NY 14221**  
**(P) 716.686.7816 (F) 978.495.9911**

**PATIENT REGISTRATION FORM (Please Print)**

Today's Date: **Thank you for selecting VKPMedical, PLLC.**

**PATIENT INFORMATION**

Patient's Last Name:		First:	Middle:	Gender:	Age:
Patient's Birth Date:		Marital Status: S    M    D    W    SEP		Social Security:	Preferred Language:
Street Address:		Apt #	City/Town:	State:	Zip Code:
Mobile Phone Number:		Work Phone Number:	Email Address:	Preferred Method of Contact: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Email	
Name of Employer:	Address:		City/Town:	State:	Zip:

**SPOUSE INFORMATION**

Last Name:	First:	Contact Number:
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**EMERGENCY CONTACT**

Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

<b>REFERRAL SOURCE</b>	<b>Primary Care Physician</b>
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How did you learn about us? Internet <input type="checkbox"/> Friend/Family <input type="checkbox"/> Physician <input type="checkbox"/> Attorney <input type="checkbox"/> Other <input type="checkbox"/>	Primary Care Physician Name:
Please list the name and number of the referral source:	Street Address:
	City, State, Zip:
	Telephone Number:

**PHARMACY INFORMATION**

Name (Local):	Address:	Telephone #:	Fax#:
Name (Mail Away):	Address:	Telephone #:	Fax#:

**HEALTH INSURANCE INFORMATION**

<b>Primary Insurance:</b> Patient's Relationship to Insured:    Self    Spouse    Child    Other:	
Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:
<b>Secondary Insurance:</b> Patient's Relationship to Insured: Self    Spouse    Child    Other:	
Secondary Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:

**SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)**

Please list your symptoms and complaints relating to your visit today:

**PATIENT REGISTRATION FORM CONTINUED (Please Print)****MEDICAL TREATMENT HISTORY**Are these symptoms related to an accident?  YES  NODid you go to the hospital?  YES  NO

If yes, list hospital name:

Were you:  Out-Patient  In-Patient

Any X-Rays/MRI's or testing performed?

Have you seen any doctors for this injury and/or condition:

 YES  NO

If yes, what type?

Medication(s) Prescribed:

**NO FAULT MOTOR VEHICLE ACCIDENT**

Insurance Company Name:

Insurance Phone Number:

Policy Holder Name:

Claim Representative:

Claim #:

Policy#

Was the accident reported to the insurance company?  YES  NOWas the accident reported to the police?  YES  NO **( If yes, provider the front desk with a copy of the police report. )**Where you the:  Driver  Passenger  Pedestrian

# of people in the Vehicle:

Where was the vehicle hit?  Front  Rear  Driver Side  Passenger SideWere you working at the time of accident?  YES  NO**WORKERS COMPENSATION-WORK ACCIDENT**

Insurance Carrier:

Employer Name &amp; Address (at the time of accident)

Claim/Carrier Case #:

WCB #:

Claim/Case Manager:

Telephone Number:

Was injury reported to your employer?  YES  NO

Name &amp; Phone number of Supervisor Reported to:

**Injury Specifications**

Date of Injury:

Accident occurred in: City:

State:

Injury resulted from:  Motor Vehicle Accident  Work Accident  Other

• If other please specify:

Do you have an attorney representing you for this injury?  YES  NO

Attorney Firm Name:

Telephone Number:

Did you miss any time at work as a result of the injury?  YES  NO

1st Date Missed:

Date of Return:

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**IF GUARDIAN, PRINT RELATIONSHIP TO PATIENT:** \_\_\_\_\_

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### New Patient Medical History Form

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

#### Chief Complaint

Where is your pain located? \_\_\_\_\_

Which is your worst pain? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

What is your pain level today (on a scale of 0-10)? \_\_\_\_\_

Does your pain radiate? If so, where: \_\_\_\_\_

What word best describes the frequency of your pain:      Constant       Intermittent

What is the quality of your pain? *Check all the following that describe your pain?*

Aching                                       Burning                                       Shooting   
Cramping                                       Dull                                       Sharp

Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Walking			
Bending Forward			
Lying on your side			
Lying on your back			
Lying on your stomach			
Rising from sitting			
Coughing/sneezing			
Driving			

**\*Now go back and CIRCLE the box to indicate the most aggravating and most relieving activities**

**Medical Treatment History:**

Are these symptoms related to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_ Did you go to the hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

Were you: Outpatient \_\_\_\_\_ In Patient \_\_\_\_\_ Name of Hospital: \_\_\_\_\_

Were any X-rays/MRI/CT scan/EMG/NCS studies?

\_\_\_\_\_

If yes, what type(s) were done, when were they done and at what facility?

\_\_\_\_\_

**Previous Treatment(s):**

Have you seen other pain management/physiatrists/surgeons for your current complaints? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list in chronological order and explain what they did for you.

Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:
Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:
Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:

Put a check next to each type of treatment you have had for your pain control in the past. Then check the column that best describes the effect of the treatment:

Treatment	Have had this	Made Pain Better	Made Pain Worse	No Change in Pain
Anti-inflammatory				
Muscle relaxants				
Narcotic pain medications				
Physical therapy				
Exercises				
Pool therapy				
Acupuncture				
Chiropractic Adjustments				
Trigger point injections				
Epidural injections				
Facet joint injections				
SI joint injections				
Spine surgery				

**Functional Status:**

**As limited by your pain condition (please answer the following questions):**

1)How long can you drive?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
2)How long can you sit?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
3)How long can you stand?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
4)How long can you walk?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
5)How many hours of sleep do you get?	1-2	2-4	3-4	4-5	5-6	7+	

<b>Past Medical History:</b>		
<b>Mark the following conditions/diseases that you have been treated for in the past?</b>		
<b>General Medical</b>	<input type="checkbox"/> Emphysema/ COPD	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Cancer - Type _____	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Kidney infection(s)
<input type="checkbox"/> Diabetes - Type _____	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Valley Fever	<input type="checkbox"/> Urinary Incontinence
<b>Head/Eyes/Nose/Throat</b>	<b>Gastrointestinal</b>	<b>Hepatic</b>
<input type="checkbox"/> Headaches	<input type="checkbox"/> Bowel Incontinence	<input type="checkbox"/> Hepatitis A (active/ inactive/ unsure)
<input type="checkbox"/> Migraines	<input type="checkbox"/> GERD (Acid Reflux)	<input type="checkbox"/> Hepatitis B (active/ inactive/ unsure)
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Gastrointestinal Bleeding	<input type="checkbox"/> Hepatitis C (active/ inactive/ unsure)
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Hypothyroidism		
<input type="checkbox"/> Glaucoma		
<b>Cardiovascular/ Hematologic</b>	<b>Musculoskeletal</b>	<b>Neuropsychological</b>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Amputation	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Bursitis	<input type="checkbox"/> Alzheimer Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Chronic Low Back Pain	<input type="checkbox"/> Depression
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Chronic Neck Pain	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Chronic Joint Pain	<input type="checkbox"/> Prescription Drug Abuse
<input type="checkbox"/> Murmur	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Joint Injury	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Stroke	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Phantom Limb Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Pacemaker/Defibrillator	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Reflex Sympathetic Dystrophy/CRPS
	<input type="checkbox"/> Tennis Elbow	<input type="checkbox"/> Other Diagnosed Conditions
	<input type="checkbox"/> Vertebral Compression Fracture	
<b>Respiratory</b>	<b>Genitourinary/Nephrology</b>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bladder infections(s)	
<input type="checkbox"/> Bronchitis		

**Past Surgical History:**

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

**Abdominal Surgery**

- Gallbladder removal \_\_\_\_\_
- Appendectomy \_\_\_\_\_
- Other \_\_\_\_\_

**Female Surgeries**

- Caesarean section \_\_\_\_\_
- Hysterectomy \_\_\_\_\_
- Laparoscopy \_\_\_\_\_

**Heart Surgery**

- Valve replacement \_\_\_\_\_
- Aneurysm repair \_\_\_\_\_
- Stent placement \_\_\_\_\_
- Other \_\_\_\_\_

**Joint Surgery**

- Shoulder \_\_\_\_\_
- Hip \_\_\_\_\_
- Knee \_\_\_\_\_

**Spine I Back Surgery**

- Discectomy (levels) \_\_\_\_\_
- Laminectomy \_\_\_\_\_
- Spinal fusion (levels) \_\_\_\_\_

**Other Common Surgeries**

- Hemorrhoid surgery \_\_\_\_\_
- Hernia repair \_\_\_\_\_
- Thyroidectomy \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_
- Vascular surgery \_\_\_\_\_

Please list any other surgeries and dates (attach an additional sheet if necessary)

- I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

**Social History**

Are you capable of becoming pregnant?  Yes  No

Work Status:  Working Full Time  Part Time  Disabled  Unemployed

Marital Status:  Married  Single  Divorced  Widowed

Alcohol Use:  Daily Limited Use  History of Alcoholism  Current Alcoholism  Never Drinks Alcohol  Drinks Alcohol Socially

Tobacco Use:  Current Tobacco User Packs per day \_\_\_\_\_ How many years smoker \_\_\_\_\_  Former Tobacco User  Has Never used Tobacco

Illegal Drug Use:  Denies Any Illegal Drug Use  Currently uses Marijuana  Formerly Used Illegal Drugs (not currently using) Which: \_\_\_\_\_

Currently Using Illegal Drugs Which: \_\_\_\_\_  Currently Using Someone Else's Prescription Medications

Have you ever abused alcohol, narcotic or prescription medications?  Yes  No

If yes which one? \_\_\_\_\_

Have you ever completed a detoxification program for either opioid or alcohol abuse?  Yes  No

If yes, where and when: \_\_\_\_\_

**Family History**

Mark all appropriate diagnoses as they pertain to your biological MOTHER AND FATHER only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: \_\_\_\_\_

- I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY       I AM ADOPTED (No Medical History Available).

**Allergies**

Do you have any known drug allergies?       Yes     No  
 If so, please list all medications you are allergic to.

Medication Name	Allergic Reaction Type
_____	_____
_____	_____
_____	_____

Topical Allergies:     Iodine    Latex     Tape      Are you allergic to shellfish?    Yes     No

**Current Medications**

Please indicate which (if any) of the following blood-thinners you are taking:

- Aggrenox     Coumadin / Warfarin     Efferent     Lovenox     Plavix     Pletal     Pradaxa  
 Prasugrel     Ticlid     Other \_\_\_\_\_

Please list all medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency

Review of Systems: Mark the following symptoms that you currently suffer from.		
<b>Constitutional:</b> <input type="checkbox"/> All Negative	<b>Eyes:</b> <input type="checkbox"/> All Negative	<b>Cardiovascular</b> <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies Excessive Seating <input type="checkbox"/> Insomnia <input type="checkbox"/> Unexplained Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness	<input type="checkbox"/> Denies Visual Changes	<input type="checkbox"/> Denies Chest Pain <input type="checkbox"/> Edema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> irregular pulse and palpitations
<b>Gastrointestinal:</b> <input type="checkbox"/> All Negative	<b>Ears/ Nose/Throat/Neck:</b> <input type="checkbox"/> All Negative	<b>Respiratory:</b> <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> stomach ulcers <input type="checkbox"/> bowel incontinence	<input type="checkbox"/> Denies difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Ringing in in ears	<input type="checkbox"/> Denies chronic cough <input type="checkbox"/> Shortness of Breath
<b>Skin:</b> <input type="checkbox"/> All Negative	<b>Musculoskeletal:</b> <input type="checkbox"/> All Negative	<b>Genitourinary:</b> <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies skin, hair and nail symptoms	<input type="checkbox"/> Denies Joint pain	<input type="checkbox"/> Denies difficulty voiding
<b>Neurological:</b> <input type="checkbox"/> All Negative		<b>Psychiatric:</b> <input type="checkbox"/> All Negative
<input type="checkbox"/> Headaches		<input type="checkbox"/> Depressed Mood <input type="checkbox"/> Suicidal Thoughts

Patients Signature: \_\_\_\_\_

Date: \_\_\_\_\_





**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: \_\_\_\_\_ Include: *(Indicate by Initialing)*

\_\_\_\_\_ **Alcohol/Drug Treatment**

\_\_\_\_\_ **Mental Health Information**

\_\_\_\_\_ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b)  By initialing here \_\_\_\_\_ I authorize \_\_\_\_\_

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

\_\_\_\_\_

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
--	--

12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
--	---

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or representative authorized by law.

\* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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**AUTHORIZATION TO RELEASE INFORMATION**

I authorize and instruct my insurance carrier, \_\_\_\_\_, to provide all information requested by **VKP Medical, PLLC.** including but not limited to state of origin of policy, deductible/co payment information and/or policy maximum information and to verify benefit eligibility, pre-certify procedures, and predetermine benefits as necessary under this policy.

**Patient Name (printed):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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

NAME AND ADDRESS OF INSURER *
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NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
--

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOUR 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
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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 THE ACCIDENT: <u>OWNER'S NAME</u> <u>MAKE</u> <u>YEAR</u>
--

THIS VEHICLE WAS:  A BUS OR SCHOOL BUS,  A TRUCK,  AN AUTOMOBILE,  
 OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES  NO

IF YES, 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 TREATMENT(S)? YES <input type="checkbox"/> NO <input type="checkbox"/>	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	---	---

17. DID YOU LOSE TIME FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ABSENCE FROM WORK BEGAN: _____	HAVE YOU RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	--

IF YES, DATE RETURNED TO WORK: \_\_\_\_\_

AMOUNT OF TIME LOST FROM WORK: \_\_\_\_\_

18. WHAT ARE YOUR GROSS 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

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

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	<input type="checkbox"/>
WORKERS' COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

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 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.

\_\_\_\_\_  
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. YOUR 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).

\*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
 VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE  
 (This form is not for verification of hospital treatment )**

NAME AND ADDRESS OF INSURER OR SELF-INSURER\*

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE\*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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PROVIDER'S NAME AND ADDRESS\* VKP Medical, PLLC  
 920 Main Street  
 Niagara Falls , NY 14301

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH 3. SEX 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

**See Attached Report**

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: \_\_\_\_\_ 7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: \_\_\_\_\_

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES  NO  IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES  NO  IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES  NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES  NO  NOT DETERMINABLE AT THIS TIME   
 IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: \_\_\_\_\_ THROUGH: \_\_\_\_\_

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

\_\_\_\_\_ (DATE)

CONTINUE ON PAGE 2

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**

**PAGE 2**

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES  NO

IF YES, describe your recommendation below:

**15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY**

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
<b>SEE ATTACHED BILL</b>				
				TOTAL CHARGES TO DATE\$

**16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:**

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
Vikas K. Pilly	MD	244731	EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY) Owner

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

**Vikas K. Pilly, MD License#: 244731**

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES  NO

19. ESTIMATED DURATION OF FUTURE TREATMENT

**Unknown at this time**

**PATIENT:** Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

**20. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

**AUTHORIZATION TO PAY BENEFITS:**

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME \_\_\_\_\_ SIGNED \_\_\_\_\_  
PATIENT
PATIENT
DATE

CONTINUE ON PAGE 3

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE  
PAGE 3**

**PATIENT:** Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

**21. (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

**ASSIGNMENT OF NO-FAULT BENEFITS:**

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE 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, NOTWITHSTANDING ANY OTHER AGREEMENT 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

PRINT NAME _____ PATIENT (Assignor)	SIGNED _____ PATIENT
PRINT NAME _____ VKP Medical, PLLC PROVIDER OF HEALTH CARE SERVICE (Assignee)	SIGNED _____ PROVIDER OF HEALTH CARE SERVICE
	DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED?       YES       NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?       YES       NO

**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.**

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.  84-2536048	WCB RATING CODE IF NONE, SPECIALTY  CPMR
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**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 VKP Medical, PLLC, ("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 to the contrary.  
(Print accident date)

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)

VKP Medical, PLLC  
\_\_\_\_\_  
(Print name of Provider)

\_\_\_\_\_  
(Signature of Provider)

920 Main Street  
\_\_\_\_\_

Vikas K. Pilly, MD, Owner  
\_\_\_\_\_

Niagara Falls, NY 14221  
\_\_\_\_\_  
(Address of Provider)

\_\_\_\_\_  
(Date of signature)

TID # 84-2536048

**Notice of Intention to Make Claim**

This form must be subscribed and sworn to. Fax or e-mail notification is not acceptable.

To: MOTOR VEHICLE ACCIDENT INDEMNIFICATION CORPORATION  
100 WILLIAM ST, 14<sup>th</sup> Floor  
NEW YORK, N.Y. 10038 phone: 646-205-7800

State of New York -  
County of \_\_\_\_\_ -ss.

Pursuant to Article 52 and/or pertinent sections of Article 18 of the Insurance Law of the State of New York, this affidavit is presented to the Motor Vehicle Accident Indemnification Corporation for the purpose of giving my Notice of Intention to Make Claim against said Motor Vehicle Accident Corp. for injuries sustained by me. I have been duly sworn and state:

My name is \_\_\_\_\_; my date of birth is \_\_\_\_\_

I reside at \_\_\_\_\_;  
Street Address /Apt City - State - Zipcode

My Social Security # is: \_\_\_\_\_ My email is: \_\_\_\_\_  
My telephone number is: \_\_\_\_\_

I am employed by: \_\_\_\_\_ [ ] Unemployed

I was involved in an automobile accident on: \_\_\_\_\_  
Month Day Year time (am/pm)

Place of Accident: \_\_\_\_\_  
Street or highway City State

I was driver [ ] a passenger [ ] of vehicle #1 [ ] a pedestrian [ ]  
vehicle #2 [ ] a bicyclist [ ]

Vehicle #1 \_\_\_\_\_ Vehicle #2 \_\_\_\_\_  
Year/Make/Model/Color Year/Make/Model/Color

License Plate #: \_\_\_\_\_ State \_\_\_\_\_ License Plate #: \_\_\_\_\_ State \_\_\_\_\_

Owner: \_\_\_\_\_ Owner: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_

Driver: \_\_\_\_\_ Driver: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_

Insured by: \_\_\_\_\_ Insured by: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

The accident was reported to the Police on \_\_\_\_\_, in \_\_\_\_\_  
Date Precinct - City - State

Description of Injury & Expense Incurred: \_\_\_\_\_

Is your injury covered by insurance? Yes [ ] \_\_\_\_\_ No [ ]  
Name of Insurance Company

Are you receiving Worker's Compensation? Yes [ ] \_\_\_\_\_ No [ ]  
Name of Insurance Co.

**Description of Accident**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Did anyone live with you on the date of accident? Yes [ ] No [ ]**

**If yes, list all the people that lived with you on the date of accident:**

<b>Name</b>	<b>Relation</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do any of the people you live with own a vehicle: Yes [ ] No [ ]  
Owners name \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Policy #: \_\_\_\_\_ Effective: \_\_\_\_\_ Expires: \_\_\_\_\_

**Witnesses to the Accident**

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Telephone: _____	Telephone: _____

Reason for application to Motor Vehicle Accident Indemnification Corporation:  
Uninsured Car [ ] Stolen Car [ ]  
Denial of Coverage [ ] *attach copy* Unidentified Car [ ]  
Disclaimer of Coverage [ ] *attach copy*

>>>>>>>>> **Attach a copy of both sides of Police Report** <<<<<<<<<<<<<<

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A 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 VIOLATION.**

Sworn to before me this \_\_\_\_\_ day \_\_\_\_\_  
Of \_\_\_\_\_, 20\_\_\_\_ (Signature of person making claim)

\_\_\_\_\_  
Notary Public (signature)

## HOUSEHOLD AFFIDAVIT

On \_\_\_\_\_ [date of accident], I, \_\_\_\_\_, resided at

\_\_\_\_\_.

I am currently residing at (if different from the above) \_\_\_\_\_.

*Check the correct response:*

- At the time of the accident I was living alone; no one else lived with me.
- or*
- The following people lived with me on the date of accident:

<u>NAME</u>	<u>Social Security #</u>	<u>DATE of BIRTH</u>	<u>RELATIONSHIP</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list ALL members of the your household, including Social Security #, dates of birth & relationship to you.                      *[use reverse if necessary]*

\*\*\*\*\* **MUST BE NOTARIZED**\*\*\*\*\*

\_\_\_\_\_

Signature                      date

Notary:

Sworn to before me this day

Of 20\_\_

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON WHO FILES A 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 VIOLATION.