

Market St. Chiropractic & Nutrition
Dr. Scott J. Beres
29 E. Market St.
Corning, NY 14830
607-936-4141

Automobile Accident Questionnaire

Please answer all questions completely and accurately

Name _____ Sex _____ Marital Status _____ Date of Birth _____
Address _____ City _____ State _____
Zip _____
Home Phone _____ Occupation _____
Who referred you to our office? _____
SSN# _____

Please be specific. Include what happened to you in the vehicle. Please list how the accident occurred. Please list damages to vehicle. Please indicate if you were wearing your seatbelt, how many passengers were in the vehicle, etc.

Please explain in detail how your accident happened?

Time and Date of Accident: _____

Please Circle. You were heading? *North *South *East *West on _____ (Rd. or Highway)

Please Circle. Other vehicle was heading? *North *South *East *West on _____ (Rd. or Highway)

Please Circle. You were struck from? * Behind *Front *Passenger side * Driver's side

Insurance Co. _____

Claim # _____

Driver of vehicle in which you were injured (if applicable) Name: _____

Insurance Co. _____

Name of Insurance Adjustor _____

Have you retained an attorney? _____ if yes, name, address & phone # _____

Were the police notified? _____ if yes, report filed? _____

Were you knocked unconscious? _____ Were you wearing a seatbelt? _____

Did you feel pain immediately after the accident? _____ if so, where? _____

Were you taken to the hospital? _____ if so, what tests were performed? _____

if so, what treatment was given? _____

Have you consulted any other doctors/practitioners? _____ if yes, whom? _____

When? _____

What treatments did you receive? _____

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Name _____ Date of injury _____

Have you had previous injury to the same areas of complaint? _____

If so, when? _____

Did you lose any work time? _____

Do any other diseases or accidents currently affect your employment? _____

In your work, do you have a history of absenteeism caused from accidents on the job? _____

Before the injury, were you capable of working on an equal basis with others of your age? _____

Please complete all information. This information is important and necessary.

Are your work activities restricted as a result of this accident? _____

If yes, how? _____

Please Circle. Since your injury are your symptoms: * improving * getting worse * the same

Are you unable to fully perform any of your daily activities? _____

If yes, explain _____

Please draw a diagram of your accident below.

**New York Motor Vehicle No-Fault Insurance Law
Assignment of Benefits Form**

I, _____ (“Assigner”) hereby assign to, Market St. Chiropractic & Nutrition (“Assignee”) all rights, privileges, and remedies to which I am entitled under Article 51 (the No-Fault provision) of the Insurance Law.

The Assignee hereby certifies that they have not received payment from or on behalf of the Assigner and shall not pursue payment directly from Assigner for services provided by the Assignee for injuries sustained due to motor vehicle accident, which occurred on _____, not withstanding any prior written agreement to the contrary.

This agreement shall become null and void if at any time it is determined that benefits are not payable due to the following circumstances: lack of coverage, violation of a policy condition, or determination that the treatment/services rendered are not related to said motor vehicle accident.

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 FRAUDULANT INSUARANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO ACIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

(SIGNATURE OF PATIENT)

(ADDRESS)

(SIGNATURE OF PROVIDER)

29 E. MARKET ST. CORNING, NY 14830
(ADDRESS)

(DATE)

**AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE
OR IF NO-FAULT CLAIM IS NOT ALLOWED**

Date of injury: _____

SSN# _____

Insured person: _____ Address: _____

Employer: _____ Address: _____

Insurance carrier: _____ Address: _____

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR NO-FAULT FOR THIS ILLNESS OR
CONDITION OR IT IS DETERMINED BY THE NO-FAULT BOARD THAT THE ILLNESS OR
CONDITION IS NOT A DIRECT RESULT OF A COMPENSABLE NO-FAULT CASE,
I, _____ HEREBY AGREE TO PAY DR. SCOTT J. BERES,
D.C., 29 E. MARKET STREET, CORNING, NY 14830 HIS USUAL AND CUSTOMARY FEES FOR
SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED
CASE.

DATE: _____ SIGNATURE: _____

IF SIGNED BY OTHER THAN CLAIMANT, PRINT BELOW:

Name & Address	Relationship	Date

Witness:

Name	Date