DR. MARK A. FERRY
DR. BRIAN M. FERRY

810 Center Road, West Seneca, NY14224
(716) 674-4254 Fax: 674-4392
WWW.WNYCHIROPRACTIC.COM

No Fault – Auto Accident

First Name: _____ **Last Name:** _____ **Initial:** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (_____**)** _____ **Home/Cell/Work** **Alt Phone: (**___**)** _____ **Home/Cell/Work**

SS#: _____ **Date of Birth:** _____ **Sex:** _____ **Marital Status:** _____

In case of an emergency, whom should we contact? (name & Phone #) _____

ACCIDENT INFORMATION

To ensure billing is submitted properly, please provide us with the following information.
(For the vehicle you were in at the time of the accident.)

Insurance company: _____ **Phone: (**_____**)** _____

Street: _____ **City:** _____ **State:** _____ **Zip:** _____

Adjuster: _____ **Adjuster's Phone:** (_____) _____

Date & time of injury: _____ **Please describe how injury occurred:** _____

_____

Policy #: _____ **Claim#** _____ **File#:** _____

Name of Policy Holder: _____ **Your relation to the insured:** _____

Body part injured: _____

Did you report the accident to your insurance company? **No** **Yes**

Did you submit the "Application of no-fault Benefits" to your insurance company? **No** **Yes**

Have you seen other doctors for this injury? **No** **Yes** **If Yes, with whom?** _____

Signature: _____ **Date:** _____

1. Did the accident render you unconscious? ☐ **Yes** ☐ **No If yes, For how long?** _____

2. Were X-Rays taken? ☐ **Yes** ☐ **No If yes, at what facility/hospital?** _____

3. Was medication prescribed? ☐ **Yes** ☐ **No If yes, list:** _____

4. Indicate the symptoms that are a result of this accident:

	Dizziness		Difficulty Sleeping		Jaw Problems		Nausea
	Memory Loss		Irritability		Arm/Shoulder Pain		Back Pain
	Headaches		Fatigue		Numb Hands/Fingers		Lower Back Pain
	Blurred Vision		Tension		Chest Pain		Back Stiffness
	Buzzing in ear		Neck Pain		Stomach Upset		Numbness/Tingling
	Stiffness		Swelling		Weakness		Other:

5. Is your condition ☐ Getting Worse ☐ Constant ☐ Comes & Goes

6. Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

7. Have you retained an attorney? ☐ Yes ☐ No If yes, whom: _____ Phone #: _____

8. How many hours are in your normal work day? _____

9. Please indicate your daily job duties and any activities which you are occasionally asked to perform:

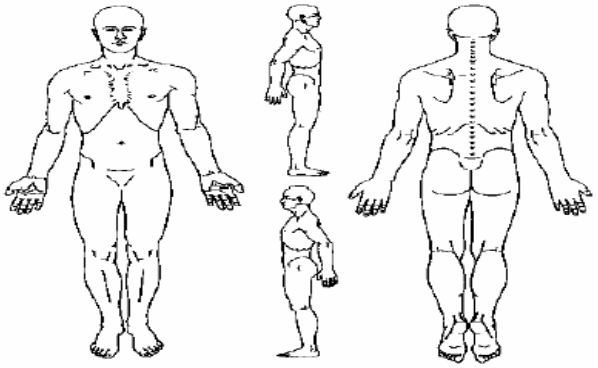
☐	Standing	☐	Lifting	☐	Operating Equipment	Other: _____
☐	Sitting	☐	Driving	☐	Working w/arms above head	_____
☐	Walking	☐	Twisting	☐	Typing	_____
☐	Crawling	☐	Bending	☐	Stooping	

10. Do you work with others who can help you with any heavy lifting? ☐ **Yes** ☐ **No**

11. While in recovery, is there any light duty work you could request? ☐ **Yes** ☐ **No**

12. My Pain Level right now: **No Pain** ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ **Worst Possible**

A = ACHE
B = BURNING
N = NUMBNESS
P = PINS & NEEDLES
S = STABBING
O = OTHER_____



On the diagram, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (See next to diagram) over the area of the body where those symptoms are occurring.

SIGNATURE:_____**DATE**_____

Please check any of the following symptoms which you now have or have had previously.
THIS IS A CONFIDENTIAL HEALTH REPORT.

ALLERGIES
- ☐ Environmental _____
- ☐ Food _____
- ☐ Medications_____
- ☐ Other _____

Gastro-Intestinal
- ☐ Abdominal Pain
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Vomiting Blood
- ☐ Vomiting Food
- ☐ Excessive Weight loss

Genito-Urinary System
- ☐ Bladder Trouble
- ☐ Burning
- ☐ Cloudy Urine
- ☐ Discharge
- ☐ Discolored Urine
- ☐ Dribbling
- ☐ Excessive Urination
- ☐ Impotence
- ☐ Painful Urination
- ☐ Scanty Urination

Eyes
- ☐ Blurred Vision
- ☐ Burning Eyes
- ☐ Cataracts
- ☐ Dryness
- ☐ Glasses
- ☐ Glaucomas
- ☐ Itchy Eyes
- ☐ Tearing
- ☐ Vision Headaches

Respiratory System
- ☐ Congestion
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Inhalent Exposure
- ☐ Non Productive Cough
- ☐ Phlegm
- ☐ Productive Cough
- ☐ Short of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Coughing Blood
- ☐ Coughing Phlegm
- ☐ Difficulty Breathing
- ☐ Heart Problem
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lung Problem
- ☐ Pain over heart
- ☐ Persistent cough
- ☐ Rapid Heart Beat
- ☐ Varicose Veins

Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Dental Problems
- ☐ Deviated Septum
- ☐ Dry Mouth
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Ear Pain
- ☐ Eye Inflammation
- ☐ Eye Strain
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nose Bleeding
- ☐ Nasal Discharge
- ☐ Recurrent infections
- ☐ Sore Gums
- ☐ Sore Throat
- ☐ Throat Pain
- ☐ Ulcers

Nervous System
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Hand Trembling
- ☐ Headaches
- ☐ Loss of Feeling
- ☐ Loss of Balance
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Tingling
- ☐ Weak grip

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)

NYS FORM NF-AOB (Rev 1/2004)

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DR. BRIAN M. FERRY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I _____ authorize the release of my medical records consisting of:

Records to be released: _____
_____
_____
_____

From your facility: _____
_____
_____
_____

Release to: □ Dr. Mark A. Ferry □ Dr. Brian M. Ferry

Western New York Chiropractic
810 Center Road
West Seneca, NY 14224

Fax # 716 – 674 - 4392

Printed:_____ Date of Birth:_____

Signed:_____

Date:_____