1045 West Jericho Turnpike
Smithtown, NY 11787
631-543-8844 Phone
631-543-8840 Fax

NO-FAULT INFORMATION/ASSIGNMENT OF BENEFITS
Patient Name____
Date of Birth ____________________
Social Security Number ______________________
__ Married __ Single __ Divorced ___Widowed
Home Address
____
(Street, City, State, Zip)
Home Phone _________________________ Business Phone _________________________
Insurance Company
____
Insured Party (Policy Holder Name) ____
SSN: _________________
Insurance
Address____
(Street, City, State, Zip)
Insurance Telephone ______________________ Adjuster __________________________
Date of Accident __________ Policy Number ________________________
Claim Number ____________________
ACCIDENT INFORMATION:
Please Mark: Driver _______/ Passenger __________/ Pedestrian _____/
Vehicle: Personal __________/ Work__________/
Description & Place of Accident:
____
____
____
Were you Hospitalized? ____Yes ____ No Name of Hospital_______________________
ATTORNEY ________________________________ Phone _______________
I authorize the release of any information relating to claims for benefits submitted on behalf of my or my dependent. I expressly agree and acknowledge that my signature on this document authorizes my doctors to submit claims for benefits and agree that services rendered or to be rendered may occur without obtaining my signature on each and every claim for me or my dependent. I request that my insurance benefits be paid directly to the providers of service and agree that any benefits not allowed by my insurance company will be my responsibility.

PATIENT SIGNATURE __________________________________ DATE: ______________