NO-FAULT REGISTRATION

PATIENT NAME (LAST, FIRST, M.I.) _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____
IF MINOR, PARENT(S) NAME:_____
PARENTS EMPLOYER:_____

HOME # _____ SEX: M ___ F ___ MARITAL STATUS: S ___ M ___ D ___ SEP ___
EMPLOYER _____ ADDRESS _____
WORK # _____ OCCUPATION _____
REFERRING PHYSICIAN _____ TELEPHONE # _____

DATE OF INJURY ___/___/___ DATE SYMPTOMS BEGAN ___/___/___
LOCATION OF ACCIDENT(**TOWN**)
_____
NAME OF POLICY HOLDER _____
INSURANCE COMPANY NAME _____
INSURANCE COMPANY ADDRESS _____
INSURANCE COMPANY TELEPHONE NUMBER _____
INSURANCE COMPANY CONTACT OR AGENT _____
FILE # _____ POLICY # _____

HAVE YOU EVER INJURED THIS BODY PART BEFORE? YES / NO IF YES, PLEASE EXPLAIN:_____

WAS THE ACCIDENT REPORTED TO YOUR INSURANCE COMPANY? YES ____ N0 ____
DID THE INJURY OCCUR WHILE WORKING? YES ____ NO ____
WERE YOU HOSPITALIZED? YES ____ NO ____
DATE OF HOSPITALIZATION: FROM_____TO _____
NAME OF HOSPITAL _____
ADDRESS OF HOSPITAL _____
WERE YOU DISABLED FROM THIS ACCIDENT? YES ____ NO ____
DATE DISABILITY BEGAN ___/___/___ ARE YOU STILL DISABLED? YES ____ NO ____
DATES OF DISABILITY: FROM _____ TO _____
WILL AN ATTORNEY BE CONTACTING US? YES ____ NO ____
IF, YES HIS/HER NAME: _____

SHOULD NO-FAULT BE DENIED PLEASE SUPPLY US WITH THE FOLLOWING INFORMATION:
COMMERICAL INSURNACE COMPANY NAME _____
COMMERICAL INSURANCE COMPANY ADDRESS _____
COMMERICAL INSURANCE COMPANY TELEPHONE # _____
SUSCRIBERS NAME _____
SUSCRIBERS EMPLOYER _____
EMPLOYERS ADDRESS _____
TELEPHONE # _____ ID # _____ GROUP # _____
IN CASE OF AN EMERGENCY PLEASE CONTACT:
NAME _____ TELEPHONE # _____

NOTE: IN CONSIDERATION OF SERVICES RENDERED OR TO BE RENDERED TO THE ABOVE NAMED PATIENT, I HEREBY AUTHORIZE ASSIGNED PAYMENT DIRECTLY TO DRS. IRA AND MARC CHERNOFF, PROVIDER OF HEALTH SERVICES. I AUTHORIZE THE PROVIDER TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO SUBSTANTIATE A CLAIM. IN THE EVENT THAT THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE INSURANCE COMPANY, DUE TO DENIAL FOR ANY REASON, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF THE PROVIDER'S CHARGES. I ALSO UNDERSTAND THAT IF I HAVE NOT YET MET MY DEDUCTIBLE UNDER NO-FAULT, I AM RESPONSIBLE FOR PAYMENT OF SUCH DEDUCTIBLE, UNDER MY POLICY COVERAGE

SIGNATURE (IF MINOR, PARENT SIGNATURE)_____ ___DATE:_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENT OF BENEFITS FORM)
(For Accidents Occurring on and After 3/1/02)

Claim Number: _____

I, _____, (Assignor") hereby assign to DR. CHERNOFF, _____, ("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 _____ notwithstanding 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)

IRA CHERNOFF, M.D., P.C. _____
(Print name of Provider) (Signature of Provider)
MARC CHERNOFF, M.D.
2500 Nesconset Hwy.
BLDG 9
Stony Brook, NY 11790

_____ _____
(Date of Signature)

_____
(Address)

NYS FORM NF-AOB (Rev 1/2004)

PLEASE FILL OUT PAGES 1 – 2 – 3

PLEASE PRINT

DATE: _____/_____/_____

HOME#: _____WORK#: _____

PATIENT'S NAME: _____ AGE: _____

REFERRING DR: _____PHONE#: _____

ADDRESS: _____

LIST IN ORDER YOUR MAIN COMPLAINTS:

1. _____
2. _____
3. _____

WHEN PROBLEMS STARTED: _____

HOW: _____

IS LITIGATION INVOLVED? (Y) (N) _____

DETAIL YOUR PROGRESS TO DATE: _____

_____

DETAIL YOUR TREATMENT TO DATE IN ORDER: _____

_____

PAST HISTORY: OPERATIONS: _____

MEDICAL ILLNESSES: _____

_____

DRUG ALLERGIES: _____

LIST CURRENT MEDICATIONS: _____

FAMILY ILLNESSES (PARENTS, ETC.): _____

TYPE OF WORK/RECREATION: _____

DO/DID YOU SMOKE? (Y) (N) IF YES, HOW MUCH? _____ HOW LONG? _____

DO YOU DRINK ALCOHOL? (Y) (N) IF YES, HOW MUCH? _____

MARITAL STATUS: MARRIED SINGLE DIVORCED OTHER _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITITONS?

_____ STOMACH PROBLEMS _____ CANCER

_____ DIABETES _____ HEART

_____ ARTHRITIS _____ EPILEPSY

_____ GOUT _____ WEIGHT LOSS

_____ SEXUAL DIFFICULTIES _____ WEIGHT GAIN

_____ BOWEL/BLADDER _____ BLEEDING

_____ THYROID _____ HEPATITIS

_____ FEVER/NIGHT SWEATS _____ HIV

OTHER PLEASE EXPAIN _____

DO YOU HAVE ANY COMPLAINTS WITH REFERENCE TO YOUR:

APPETITE ____HEAD____EYES____EARS____NOSE___HEART/LUNGS___ KIDNEYS____

FEMALE PATIENTS: DATE OF LAST MENSTRUAL PERIOD/MENOPAUSE: ____/____/____

ARE YOU CURRENTLY BREAST FEEDING? YES NO

ANY POSSIBILITY OF PREGNANCY? YES NO

ANY PROBLEMS WITH YOUR JOINTS?

HIPS___KNEES___ANKLES___FEET___SHOULDERS___ELBOWS___WRISTS___HANDS___

WERE X-RAYS TAKEN? YES NO IF SO, WHERE/WHEN _____

PLEASE CIRCLE THE DIAGNOSTIC TEST(S) YOU HAVE HAD:

CT SCAN MYELOGRAM DISCOGRAM MRI EMG BONE SCAN DATE: ___/___/___

NAME AND TELEPHONE OF FACILITY: _____

DO YOU PLAN TO BE AT YOUR REGULAR JOB IN SIX MONTHS? YES NO

HAVE YOU EVER BEEN INCAPACITATE AND UNABLE TO WORK? YES NO

IF YES, FROM ____/____/____ TO ____/____/____

NAME/ADDRESS OF ATTORNEY YOU WOULD LIKE YOUR REPORTS SENT TO: _____

_____.

PATIENTS SIGNATURE: _____