EAR NOSE & THROAT ASSOCIATES OF NASSAU COUNTY

2870 Hempstead Turnpike, Suite 203, Levittown, NY 11756	Telephone: (516) 731-6644	Fax: (516) 731-8746
165 North Village Avenue, Suite 117, Rockville Centre, NY 11570	Telephone: (516) 764-1055	Fax: (516) 764-1062
333 Glen Head Road, Suite 110, Old Brookville, NY 11545	Telephone: (516) 671-5511	Fax: (516) 671-5210

NO FAULT INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Is Patient a Minor? _____ Parent/Guardian _____

Date of Accident: _____

What part of the body did you injure? _____

Are you out of work as a result of this injury? _____ Date you returned to work? _____

NO FAULT INSURANCE INFORMATION

Insurance Carrier: _____

Carrier Address: _____

Policy Holder Name: _____

Policy Number: _____

File Number: _____

Claim Adjuster: _____ Phone #: _____

Fax #: _____

Name of Attorney: _____ Phone #: _____

By signing below: I hereby authorize my health care provider(s) to file claims to the above No Fault carrier on my behalf and that payment should be sent directly to my health care provider(s). In the event that No Fault denies this claim, I hereby agree to pay my health care provider(s) their usual and customary fees for the services rendered to the above named claimant in the above identified case. I understand that if my health care provider(s) does not receive payment from the insurer, I am personally responsible for the payment of the provider's charges.

Signature: _____ Relationship to patient: _____

Date: _____