Borio Chiropractic Health Center
P.O. Box 1890, 8212 Brewerton Road, Cicero, New York 13039
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No-Fault/Personal Injury

Patient Name:_____ Date of Accident:_____

Claim #:_____ File #:_____

Name of Insured:_____ Insured's SS#:_____

Insured's Insurance Coverage:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ Claims Adjuster:_____

State in which accident occurred:_____

Were you… ( ) the driver ( ) the passenger

Briefly, how did the accident occur?_____

_____

_____

Type of bodily injury:
( ) Neck ( ) Upper Back ( ) Lower Back ( ) Other:_____
Are you currently working? ( ) Yes ( ) No
Working status: ( ) Part-time ( ) Full-time ( ) Retired
Can you perform your *regular* work?( ) Yes ( ) No Last day worked:_____
If you missed work, give details:_____
Can you perform any work? ( ) Yes ( ) No
What date did you resume limited work duty?_____
What were your work restrictions?_____
What date did you resume *regular* work?_____

Total Disability Start Date:_____ Partial Disability Start Date:_____
Total Disability End Date:_____ Partial Disability End Date:_____

Attorney Name:_____ Telephone #_____
Firm Name:_____
Address:_____
City:_____ State:_____ Zip:_____

I authorize my insurance benefits to be paid directly to this office and I also authorize the doctor to release any medical information required to assist in collecting fees from my insurance company. In the event I fail to pursue/prosecute the claim for this illness or condition, or if it is determined at a hearing by a law judge, that the illness or condition is not a direct result of the said injury, I hereby agree to pay Dr. Joseph Borio his usual and customary fees for this services rendered to me in this case.

Signature:_____ Date:_____