Richard S. Obedian M.D., PLLC

NO FAULT INFORMATION

Name:_____
Address:_____
_____
SS No._____
Date of Birth:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Date of Accident:_____

NO FAULT INSURANCE CARRIER
Ins. Co. Name_____
Address:_____
_____
_____
Telephone No._____
Policy Holder's Name:_____
Policy No._____
Claim No._____

Were you a: Driver Passenger Pedestrian

Relationship of patient to Auto Owner: Patient Spouse Child Other

List all body parts that were injured as a result of the motor vehicle accident:

_____

_____

Briefly describe how accident occurred:

_____

_____

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Please fill in the following if applicable:

Attorney's Name:_____
Firm's Name:_____
Address:_____
_____
Phone No._____

"I verify the accuracy of the above information and I authorize the release of information as provided on this form. I also authorize the assignment of benefits directly to Richard S. Obedian M.D., PLLC understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian M.D., PLLC to submit a claim to the insurance carrier or its intermediaries for all covered services rendered for radiology and orthopaedic care and authorize and direct the insurance carrier or its intermediaries to issue payment check(s) directly to Richard S. Obedian M.D., PLLC.

SIGNATURE____________________________________ **DATE**____________________