AUTO NO-FAULT INFORMATION

PATIENT INFORMATION		
NAME:		DATE of BIRTH:
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:	SS#:	
OCCUPATION:		
Who may we thank for referring you?		

AUTO INSURANCE CARRIER (for office use)	
CARRIER NAME:	ID NUMBER:
CARRIER ADDRESS:	
CLAIM#:	
COVERAGE VERIFIED BY:	
ADJUSTERS NAME:	TELEPHONE:
POLICY NUMBER:	
DATE OF ACCIDENT:	

ATTORNEY INFORMATION	
ATTORNEY NAME:	
ADDRESS:	
TELEPHONE:	FAX:

AUTHORIZATION

I do authorize the No Fault Insurance Carrier or Medical Services to release information to SCARPA PHARMACY that relates to my medical case. The information released shall pertain to my physical and medical conditions necessitating the rental or purchase of medical equipment, supplies and/or drugs.

PATIENTS SIGNATURE: X **DATE:**