Peter Hughes, MD
526 Glen St.
Glens Falls, NY 12801

No-Fault Questionnaire

Name ____ Age _________ Social Security # ___________________

Address ____

Driver's Name _____________________________ Driver's Address _________________________________

____

Date of Accident ____________________ Your Local Insurance Agent ______________________________________

Address where accident occurred ____

Was alcohol a factor in this accident? (optional) ☐ Yes ☐ No If yes, please specify ______________

____

Driver's No-Fault Insurance Company ____

Driver's No-Fault Insurance Company Address ____

Driver's No-Fault Insurance Company's Phone Number ____

Did patient present to the E. R.? ☐ Yes ☐ No Was the patient hospitalized? ☐ Yes ☐ No

Were x-rays taken? ☐ Yes ☐ No If yes, date x-rays were taken _________________________________

I accept financial responsibility and promise to pay for all charges billed by **Peter Hughes, MD** to this account.

_______________________________________ _______________________________________
Signature Date