

Baher Yanni, M.D.

PRIMA PAIN RELIEF

BOARD CERTIFIED ANESTHESIOLOGIST

BOARD CERTIFIED IN PAIN MANAGEMENT

(732)698-1000 Fax (732)698-1008

Motor Vehicle/Workers Compensation Form

Patient Name: _____ SS#: _____

Patient Address: _____

Patient Phone #:(____) _____ - _____ DOB: _____

Date Of Accident: _____ Injuries: _____

Did you go to the hospital? Y N Any other x-rays taken Y N

Insurance: _____

Claims mailing address _____

Claim #: _____ Policy #: _____

Adjuster _____

Phone _____ Fax: _____

Insured _____ Date of Birth _____

Relationship _____

Which is primary: Health Auto

If this is an auto accident, have you completed the Auto Insurance PIP form Y N

Nurse Case Manager Name _____

Phone #: (____) _____ Ext: _____ Fax #: _____

Precertification phone number _____ Fax _____

Office Visit: Y N X-rays: Y N In office procedures Y N DME: Yes No