Patient Information:

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone:(_____)_____ Work Phone:(_____)_____ Ext: _____

Cell Phone:(_____)_____ Social Security #:(Leave Blank for Minor): _____

Date of Birth: _____ Please Circle The Injury Site: Neck Shoulder Arm Elbow Hand

Email Address: _____

Surgery Date(If Applicable) _____ Back Hip Leg Knee Ankle Foot

Provide your best estimate of when you first experienced signs or symptoms: _____

Are you: (Circle One): Single Married Other

Are you a Student (Circle One)? : Yes No If Yes: Full Time Part Time

Are you Employed (Circle One)? : Yes No If Yes: List Employer _____

Is Your Injury Related To: An Accident at Work? Yes No A Motor Vehicle Accident? : Yes No State where it occurred: _____

Did Your Injury Occur During a School Related Activity? YES NO If YES Paperwork Filed w/ School? YES NO

Check any of the following services you have had this year:

Physical Therapy: _____ Occupational Therapy _____ Speech Therapy _____ Chiropractic _____

Name of the Doctor Who Referred You to Physical Therapy: _____

City/Town Where your Doctor is Located: _____

How did you hear about Accucare Physical Therapy: _____

Person to Call in Case of an Emergency: _____ Phone: (_____)_____

Primary Insurance Information:

Name of Primary Insurance Carrier: _____ ID #: _____

Your Relationship to the Insured Person for your Primary Insurance Coverage (Circle): Self Spouse Child Other

Insured Person's Information (Skip this Section if Self):

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Street: _____ City: _____ State: _____ Zip: _____

Social Security #: _____

Home Phone:(_____)_____ Work Phone:(_____)_____ Ext: _____

Date of Birth: _____ Employer: _____

Secondary Insurance Information (Complete Only if Applicable):

Name of Secondary Insurance Carrier: _____ ID #: _____

Your Relationship to the Insured Person for your Secondary Insurance Coverage (Circle): Self Spouse Child Other

Insured Person's Information (Skip this Section if Self):

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone:(_____)_____ Work Phone:(_____)_____ Ext: _____

Social Security #: _____

Date of Birth: _____ Employer: _____

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to Accucare Physical Therapy and Sports Medicine, PA. I also Acknowledge by signing below I hereby accept the terms and agreements made by the attached *Accucare Physical Therapy and Sports Medicine PA – Patient Registration and Consent For Medical Treatment Form.*

_____ _____ _____

Patient/Responsible Party Signature Relationship to Insured Date