

**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  
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: \_\_\_\_\_

Date your Prescription was written by your Doctor (Leave Blank if unknown): \_\_\_\_\_

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