East Athens Physical Therapy

PATIENT REGISTRATION - WORKER'S COMPENSATION

Today's Date: _____ Area of Injury to be treated: _____

Name: _____
First **MI** **Last**

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Cell Phone: _____ - _____ - _____ Home Phone: _____ - _____ - ____ Work Phone: _____ - _____ - _____

SSN: _____ - _____ - _____ Male / Female Marital Status: M S D W

Date of Birth: ____ / ____ / _____ E-Mail: _____

Emergency Contact: _____ Phone: _____ - _____ - _____

How did you hear about us? _____

Have you had physical therapy before? Y / N If yes, when? _____

Physician Information

Primary Care Physician Name: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Referring Physician Name: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Date of return visit: ____ / ____ / _____

Employer Information Occupation: _____

Employer: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Worker's Compensation Claim Information

Claim Information: Insurance Company Name: _____

Have you completed and returned a Personal Injury Protections application to the insurance company? Y / N

Claim Number: _____ Claims Adjuster: _____

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____ Email: _____

Attorney Information: Name: _____

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____ Email: _____

Address: _____
Street **City** **State** **Zip**

East Athens Physical Therapy

PATIENT REGISTRATION – MOTOR VEHICLE ACCIDENT

Today's Date: _____ Area of Injury to be treated: _____

Name: _____
First **MI** **Last**

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Cell Phone: _____ - _____ - _____ Home Phone: _____ - _____ - ____ Work Phone: _____ - _____ - _____

SSN: _____ - _____ - _____ Male / Female Marital Status: M S D W

Date of Birth: ____ / ____ / _____ E-Mail: _____

Emergency Contact: _____ Phone: _____ - _____ - _____

How did you hear about us? _____

Have you had physical therapy before? Y / N If yes, when? _____

Physician Information

Primary Care Physician Name: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Referring Physician Name: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____

Date of return visit: ____ / ____ / _____

Employer Information Occupation: _____

Employer: _____

Address: _____
Street **Apt #** **P.O. Box**

_____
City **State** **Zip**

Motor Vehicle Claim Information

Claim Information: Insurance Company Name: _____

Have you completed and returned a Personal Injury Protections application to the insurance company? Y / N

Claim Number: _____ Claims Adjuster: _____

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____ Email: _____

Attorney Information: Name: _____

Phone Number: _____ - _____ - _____ Fax Number: _____ - _____ - _____ Email: _____

Address: _____
Street **City** **State** **Zip**