

WORKER'S COMPENSATION, AUTO OR PI CASES



Please check which clinic you will be attending therapy.
Please remember to bring your picture ID and insurance cards.

- { } Belvidere Physical Therapy- Belvidere, IL { } Marengo Physical Therapy- Marengo, IL
{ } McHenry County Physical Therapy- McHenry, IL { } Ogle County Physical Therapy- Byron, IL
{ } Poplar Grove Physical Therapy- Poplar Grove, IL { } Roscoe Physical Therapy- Roscoe, IL

Primary Care Physician: _____

Referring Physician: _____

Patient Name: _____ DOB: ____/____/____
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Social Security # _____ - _____ - _____ Part of body injury relates to: _____

Attorney Information

Attorney Name: _____ Phone #: (____) _____

Firm Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Services due to:

_____ **Workers Compensation** **Date of Injury:** _____

Employer Name: _____

Employer Address: _____

Send Claims to: _____

Claim Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (____) _____

Contact Name (Adjuster): _____ Claim #: _____

Patient Name: _____

Services due to:

_____ **Auto Accident** **Date of Injury:** _____ **Passenger or Diver (circle one)**

Patient's Auto Insurance: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (____) _____

Contact Name (Adjuster): _____ Claim #: _____

Policyholder Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (_____) _____

Name of **Liable Party** (At fault driver): _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Policyholder: _____

Liable Party's Auto Insurance: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____) _____

Contact Name (Adjuster): _____ Claim #: _____

Policyholder Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone #: (_____) _____

Services due to:

_____ **Personal Injury** **Date of Injury:** _____

Send Claims to: _____

Claim Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____) _____

Contact Name (Adjuster): _____ Claim #: _____

Liable Party Location: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Phone #: (_____) _____

Patient/ Guardian Signature: _____ Date: _____