



WORKER'S COMPENSATION, AUTO OR PI CASES

Please check which clinic you will be attending therapy at.
Please remember to bring your insurance card.

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

Form completed by: _____

Date form completed: _____

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 #: (_____) _____