Penrose & ASSOCIATES Physical Therapy

PERSONAL INJURY FORM

Patient Name: _____
Date of Accident/Injury: _____/_____/_____ Time: _____ AM/PM
Sate:____ City: _____ Injured Body Part (neck, back etc.):_____
( ) Driving my car ( ) Passenger in my car ( ) Pedestrian
( ) Driving another's car ( ) Passenger in another's car ( ) Other:_____

_____

Please list information regarding your automobile insurance company (or the insurance company of the owner of the vehicle in which you were a passenger or driver) and the insurance company of the third party (other driver involved). If this injury is not related to an automobile accident, please list the insurance company of the other party.

Your Auto (PIP) Insurance Company: _____
Mailing Address: _____ State:____ City: _____ Zip:_____
Insured Name: _____ Claim#:_____
Insured Date of Birth: _____/_____/_____
Claim Adjuster: _____ Phone: _____

Third Party Insurance Company: _____
Mailing Address: _____State:____ City: _____ Zip:_____
Insured Name: _____ Claim#:_____
Insured Date of Birth: _____/_____/_____
Insured Address: _____ State:____ City: _____ Zip:_____
Claim Adjuster: _____ Phone: _____

I do not wish insurance billing or medical records issued to this party without my release: Signature:_____ Reason: _____

Please check the appropriate boxes below:
I have automobile insurance PIP (Medical) coverage: ( ) Yes ( ) No
My automobile insurance PIP is exhausted: ( ) Yes ( ) No
I have personal Medical Insurance: ( ) Yes ( ) No
I have retained an Attorney: ( ) Yes ( ) No
If yes: Attorney's name: _____ Phone#:_____
Mailing address: _____State:____ City: _____ Zip:_____

Patient Signature: _____ Date: ____/____/_____