# SportsCare Physical Therapy, PC

**Date of call**________________ **Receptionist**________________ **Appt. date/time**________________

**Name**________________________ **Date of Birth**________________ **SS#**________________

**Address**________________________ **City**________________ **St**______ **Zip**______

**Home Phone**________________ **Cell Phone** ________________ **Email address**________________

**Present Employer Name/Address**________________________ **Work Phone**________________

**Occupation**________________________ **Employment Status**________________

**M S W D Spouse**________________ **If Child, Parents Names**________________

**Emergency contact**________________________ **Relationship to patient** ________________

**Home Phone**________________ **Work Phone**________________ **Cell Phone**________________

**Referring MD**________________ **Town**____________ **Primary Care** ________________ **Town**____________

**Orthopedist** ________________ **Town** ____________ **Cardiologist** ________________ **Town** ____________

**Rheumatologist** ________________ **Town**____________ **Neurologist** ________________ **Town**____________

**Diagnosis**________________________________

**Was this the result of a car accident or work related injury?**________ **Date of accident** ________________

Did you have previous physical therapy this year?____________ If yes, how many visits________________

How did you hear about us: Patient__________ YB____ Exterior Sign___ MD Referral______ Insurance ______ Web_____

---

**NF WC MC HMO PPO SP**

**PRIMARY INSURANCE:**

Co:____________________ Address________________________ Phone________________

ID# ________________ Grp# __________ Subscriber________________ DOB:________________

Subscriber SS#____________________ Relationship to patient____________________

**SECONDARY INSURANCE:**

Co:____________________ Address________________________ Phone________________

ID# ________________ Grp# __________ Subscriber________________ DOB:________________

Subscriber SS#____________________ Relationship to patient____________________

---

## WORKERS COMP/NO FAULT INSURANCE:

Co Name________________________________

Address________________________ Phone________________ Fax____________

WCB#________________ Carrier Case #________________ File/Claim#________________

Policy #________________ Policy Holder________________ Claim Rep________________

Employer at time of accident________________________________

Attorney Name/Address/Phone

---

I authorize SportsCare Physical Therapy, PC to release any information to my insurance company that is necessary to expedite the payment ( my claims. I understand that I am responsible for all charges not covered by my insurance including co-payments, co-insurance an deductibles. I understand that if my account is placed in collection, I am responsible for any and all fees associated with being placed int collection and legal proceedings. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions whe appropriate and that if said referrals are not obtained, I am responsible for the charges not covered under the referral. I authorize benefits to b paid to SportsCare Physical Therapy, PC. I authorize SportsCare Physical Therapy, PC to contact the insurance commissioner on my behal In the event that my workers compensation or no fault claim is denied, I will make arrangements with SportsCare Physical Therapy, PC to b paid by my private insurance and/or myself.

Patient Signature (or Signature of Parent or Guardian)________________________ Date____________