

Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

PATIENT REGISTRATION

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of Accident _____ How did it happen? Auto Work Other (location)

Involvement in Accident if Auto Driver Passenger Pedestrian Cyclist

Attorneys Name/Address/Phone _____

Insurance Company (Workers Comp or Auto PIP) _____

Address _____ Phone Number _____

Claim Number _____ Adjuster _____ Name of Insured _____

IF YOU ARE SENT FROM STATE AGENCY

Arc (Letter is required) _____ Rep Name _____

DSS (Letter is required) _____ Social Worker Name _____

SMCPS (Letter and IEP required) _____ Special Ed Supervisor Name _____

Address _____ Phone Number _____

School Name _____

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICE OR WHOM WE CAN THANK.

- | | | |
|--|---|---|
| <input type="checkbox"/> I was a Former Patient | <input type="checkbox"/> Former Patient recommendation | Name _____ |
| <input type="checkbox"/> Doctor recommendation | <input type="checkbox"/> Family or Friend recommendation | Name _____ |
| <input type="checkbox"/> Insurance Company recommendation | <input type="checkbox"/> Employer recommendation | <input type="checkbox"/> Case Manager recommendation |
| <input type="checkbox"/> Health Club recommendation | <input type="checkbox"/> Newspaper advertisement | <input type="checkbox"/> Yellow Page advertisement |
| <input type="checkbox"/> Clinic Sign | <input type="checkbox"/> Billboard advertisement | <input type="checkbox"/> Web Page |
| <input type="checkbox"/> TV advertisement | <input type="checkbox"/> Radio advertisement | I learned about you another way. _____ |

PATIENT CERTIFICATION AND SIGNATURE

I certify that all of the information provided herein is true and correct

Patient/Guardian Signature: _____ Date: _____

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