P R O S P E C T

Rehabilitation

Physical Therapy Services

PATIENT REGISTRATION

Workers Compensation and Motor Vehicle Accident Information

Patient Last Name_____ First Name_____ Middle Initial____

You are being seen today for injuries resulting from:

- ❑ motor vehicle accident
- ❑ work accident

Date of accident:_____

State in which the accident occurred:_____

If a work accident, please complete the following:

Employer Name:_____

Name of Supervisor or other individual at work who will be handling your claim:_____

Telephone number for the individual listed above:_____

If a motor vehicle accident, please complete the following:

You were the: ❑ driver ❑ passenger ❑ motorcyclist ❑ pedestrian

You collided with: ❑ car ❑ non-car vehicle ❑ stationary object ❑ pedestrian

❑ animal ❑ other:_____ ❑ no collision

Insurance Information:

Claim Number:_____ Insurance company covering this claim:_____

Name of insurance agent or case manager:_____ Telephone number:_____

To be completed by Prospect staff:

Claims Address: Authorization received: