plan physical therapy
injury . recovery . connected

Worker's Comp/Motor Vehicle/Personal Injury

Patient Name: First_____ MI____ Last _____ DOB:_____
SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

○ Male ○ Female ○ Single ○ Married ○ Divorced ○ Other Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

E-mail address: _____ Cell Phone: (_____)_____

Student: ○ Yes ○ No School: _____

Referring Doctor: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Area of Treatment: _____ Referred by: _____

	Condition Related to:	Letter of protection obtained?
Date of injury: ____/____/____	Employment? ○ Yes ○ No	○ Yes ○ No
Date of Surgery: ____/____/____	Auto Accident? ○ Yes ○ No	Auto Ins has Medical? ○ Y ○ N
Date of Accident: ____/____/____	Other Accident? ○ Yes ○ No	Need copy of declarations page

Auto/Worker's Comp Insurance: _____ Case/Claim #: _____

Adjuster/Caseworker's Name: _____ Phone #: _____

Attorney: _____ Phone #: _____

How did you hear about Plan PT? _____ _____

What would be your preference if we were to thank you for referring a friend to Plan PT? Starbucks -or- Jamba Juice

8525 N. Cedar Avenue, Suite #109 www.planphysicaltherapy.com p: 559.440.9200
Fresno, CA 93720 f: 559.440.9222