Wrightstown Family Medicine, P.C.

Paul Caracappa, D.O. ● Ellen H. Kim, M.D. ● Shannon Sell, PA-C
2189 Second Street Pike
Wrightstown, PA 18940
215-598-1200

Name _____ DOB _____ Male _____ Female _____

Address _____ City, State, Zip _____

Phone _____ Occupation _____

Emergency Contact _____ Phone # _____ Relation _____

Employer _____ Phone _____

Employer Address _____ City, State, Zip _____

Supervisor _____

Type of Accident: Motor Vehicle __ Slip & Fall __ Workman's Comp __ Are there Panel Doctors? Yes No

Date of Accident _____ Was this accident reported? Yes __ No __ Date reported: _____

Vehicle Insurance Name _____ Claim # _____

Address _____ City, State, Zip _____

Phone #: _____ Adjustor Name _____

Policy #: _____ Policy Holder _____Relation _____

Health Insurance _____ Co-Pay $_____

Insurance ID # _____ Group # _____

Policy Holder _____ DOB _____ Relation _____

Do you have an attorney? Yes _____ No _____

Name _____ Phone #: _____

Address _____ City, State, Zip _____

History of Accident: (Please describe how the accident happened, etc): _____

_____

_____

_____

Have you been able to work due to the accident? Yes _____ No _____ Last Date of Work _____

Does anyone else in the household own a car? Yes _____ No _____

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AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND MAILED DIRECTLY TO THE ABOVE ADDRESS: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for the services rendered for those services. I understand that if I voluntarily decide to continue treatment at this facility, with a Letter of Protection from my attorney, following the exhaustion of my medical benefits that the charges I incur will be paid to this facility prior to my case's settlement.

SIGNED (Insured Person): _____

DATE: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize the physician treating me to release any medical information acquired during the course of the treatment upon the request of my insurance carrier.

SIGNED (Patient or Parent, if minor): _____

DATE: _____

WORKMAN'S COMPENSATION PATIENTS ONLY (Please sign)
I hereby authorize the physician treating me to release any medical information acquired during the course of my treatment to my current employer.

SIGNED (employee): _____

DATE: _____