PATIENT DATA CARD

Patient Name: DOB

Home Phone: Cell:

Home Address:

City: State: Zip Code:

Email Address: Social Security #:

Gender: ☐ Male ( ) Female Type of Coverage: ( )Work Comp ( ) Auto

(IF WORKERS COMP)Employer Name:

Employer Address:

City: State: Zip Code:

Phone Number:

Workers Comp Carrier:

Workers Comp Adjuster:

Workers Comp Phone #:

Auto Insurance Carrier:

Auto Insurance Adjuster:

Auto Insurance Phone #:

Workers Comp/Auto Address:

City: State: Zip Code:

Claim Number: Date Of Accident:

Accident Related to:

What state did your accident occur in? :

Injury Sustained in Accident:

Name of Doctor who you are seeing for your injury(s):

Doctor's Address:

City: State: Zip Code:

Phone Number: Fax Number:

Print and Mail/Fax to: GTH Complete Injury Care 200 E Arch St, Pottsville, Pa 17901 / Fax: 570-628-5080