

Wrightstown Family Medicine, P.C.  
Paul Caracappa, D.O.  
2324 Second Street Pike  
Wrightstown, PA 18940-4110

DATE OF ACCIDENT: \_\_\_\_\_

NAME OF INSURANCE CO. & ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ ADJUSTER: \_\_\_\_\_

NAMED OF INSURED: \_\_\_\_\_ CLAIM#: \_\_\_\_\_

DO YOU HAVE AN ATTORNEY?    YES    NO

NAME/ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PLACE OF ACCIDENT: \_\_\_\_\_

HISTORY OF ACCIDENT (Please tell how the accident happened, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU BEEN UNABLE TO WORK DUE TO THE ACCIDENT?    YES    NO

LAST DATE OF WORK: \_\_\_\_\_

DO YOU HAVE NO-FAULT INSURANCE?    YES    NO

DOES ANYONE IN THE HOUSEHOLD OWN A CAR?    YES    NO

PLEASE LIST YOUR MEDICAL INSURANCE COVERAGE:  
\_\_\_\_\_  
\_\_\_\_\_

Wrightstown Family Medicine, P.C.

Paul Caracappa, D.O.

2324 Second Street Pike

Wrightstown, PA 18940-4110

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: \_\_\_\_\_