Patient Information

Social Security # ________-________-________

Patient Name: ____ Email: ______________________________
(Last) (First) (M.I.) (For appointment purposes only)

Address: ______________________________ City: ________________________ State: _____ Zip: ________

Phone: Home ( ) ______-________ Work ( ) ______-________ Ext.____ Cell ( ) ______-________

Date of Birth: ______/______/______ Sex: M F Marital Status: M S D W U

Employer Name and Address: ____

Responsible Party Information

Relation to Patient: Self ______ Spouse ______ Parent ______ Other ______

Name: ____
(Last) (First) (Middle)

Address: ______________________________ City: ________________________ State: _____ Zip: ________

Phone: Home ( ) ______-________ Work ( ) ______-________ Ext.____ Cell ( ) ______-________

Social Security # ________-________-________ Date of Birth: ______/______/______

Insurance Information

Primary Insurance

Carrier's Name: ___________________________________ Phone No. ( ) _______-___________

Address: ______________________________ City: ________________________ State: _____ Zip: ________

Policy/I.D. #: ______________________ Group #____________________ Group Name: _____________________

Authorization/Pre-Certification #:__________________________

Secondary Insurance

Carrier's Name: ___________________________________ Phone No. ( ) _______-___________

Address: ______________________________ City: ________________________ State: _____ Zip: ________

Policy/I.D.: ________________________Group #______________________ Group Name: __________________

Workman's Compensation/No Fault (Please Circle One)

Date of Accident: ______/______/______ Policy/Claim ID: _______________ Auth/Pre-Cert#: _______________

Carrier's Name: ___________________________________ Phone No. ( ) _______-___________

Address: ______________________________ City: ________________________ State: _____ Zip: ________

Contact Person/Attorney Name: ______________________________ Phone No. ( ) _______-___________

Address: ______________________________ City: __________________________ State: _____ Zip: ________

Accident Information

Referring Physician: _______________________________________ Phone No. ( ) _______-___________

Diagnosis: _________________________ Prescription date: ______/______/______ Therapist: ________________

Payment Agreement: If for any reason my claim is denied and payment for physical therapy is stopped, I agree to pay in full any charges that are outstanding.

Signature: ______________________________________ Date: ______/______/______