

PHYSICAL THERAPY, ETC

PATIENT INFORMATION

NAME : MR. ___ MRS. ___ MS ___ FIRST _____ LAST _____ DOB: _____

ADDRESS: STREET & NUMBER _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMAIL: _____ SS# _____ - _____ - _____ MALE _____ FEMALE _____

EMPLOYER _____ EMPLOYER PHONE _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____ PHONE: _____

HAVE YOU RECEIVED ANY OTHER THERAPY, CHIROPRACTIC CARE OR HOME THERAPY THIS YEAR? YES _____ NO _____

INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

NAME OF INSURED: _____ DOB OF INSURED: _____

RELATIONSHIP TO PATIENT: _____ PHONE# OF INSURED _____

ADDRESS OF INSURED (IF DIFFERENT FROM PATIENT):

SECONDARY HEALTH INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

NAME OF INSURED: _____ DOB OF INSURED: _____

RELATIONSHIP TO PATIENT: _____ PHONE# OF INSURED _____

ADDRESS OF INSURED (IF DIFFERENT FROM PATIENT):

WORKMEN'S COMPENSATION CASE? _____ **AUTO ACCIDENT CASE?** _____ **CLAIM #** _____

INSURANCE COMPANY NAME: _____ PHONE # _____

DATE OF INJURY: _____ CLAIMS ADJUSTER: _____

IF THIS IS A WORKMEN'S COMPENSATION CASE WE MUST HAVE:

EMPLOYER AT TIME OF INJURY: _____ PHONE#: _____

ADDRESS: _____