PATIENT INFORMATION

PATIENT NAME	SOCIAL SECURITY NUMBER BIRTHDATE
ADDRESS	DATE OF INJURY OR ONSET DATE:
CITY, STATE, ZIP	INJURY DUE TO: (◯) MVA (◯) ON THE JOB (◯) SURGERY (◯) CHRONIC (◯) OTHER
HOME PHONE (including area code)	(◯) SINGLE (◯) MARRIED (◯) DIVORCED (◯) WIDOWED (◯) MALE (◯) FEMALE
PATIENT'S EMPLOYER	**PLEASE COMPLETE THE SPOUSE OR PARENT INFORMATION BELOW. INSURANCE WILL NOT PROCESS CLAIMS WITHOUT THIS INFORMATION.**
ADDRESS	SPOUSE OR PARENT (IF PATIENT IS STILL COVERED UNDER PARENT'S INS)
CITY, STATE ZIP	SPOUSE OR PARENT'S SOCIAL SECURITY NO. BIRTHDATE
PHONE (including area code)	SPOUSE OR PARENT'S EMPLOYER PHONE (including area code)

P L E A S E P R E S E N T Y O U R I N S U R A N C E C A R D S F O R C O P Y I N G.

(◯) COMMERCIAL (◯) BCBS (◯) AUTO (◯) WORKERS COMP (◯) MEDICARE (◯) MEDICAID (◯) OTHER:

PRIMARY INSURANCE:	**SECONDAY INSURANCE:**

COMPLETE THE FOLLOWING SECTION IF THIS IS A MOTOR VEHICLE ACCIDENT (MVA) OR WORKERS COMPENSATION CLAIM. WE MUST HAVE THE CLAIM NUMBER. (Please supply copies of commercial insurance cards as well.) C L A I M N U M B E R :

INSURANCE COMPANY NAME	ADJUSTOR'S NAME AND TELEPHONE EXTENSION
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP	INSURANCE COMPANY PHONE (including area code)

IN CASE OF ACCIDENT OR EMERGENCY, WHOM SHOULD WE CONTACT?

NAME RELATIONSHIP

ADDRESS (include city, state, zip)

DAYTIME PHONE PAGER EVENING PHONE CELL PHONE

I hereby consent to treatment and authorize this medical service provider to furnish my insurance companies, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to this medical service provider by commercial or government insurance companies for treatment and supplies provided, not to exceed my indebtedness.

I understand that I am financially responsible to this medical service provider for all expenses incurred, and that my insurance carrier may apply amounts to deductible, copays, and/or coinsurance, for which I will be billed and must pay to this medical service provider. If there is a question regarding the payment or denial of any claims, I understand that I must contact my insurance representative for clarification. I further understand that if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

Signature	**Date**

F O R O F F I C E U S E O N L Y

DIAGNOSIS & CODE	**TREATING THERAPIST:**
DX: **TX:**	
REFERRING PHYSICIAN (first & last name) **UPIN #**	**NPI**