

OUTPATIENT PHYSICAL THERAPY AND REHABILITATION SERVICES



HOW DID YOU HEAR ABOUT OUR CLINIC: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

MALE _____ FEMALE _____ DOB: _____ SS# _____

HOME PHONE: _____ WORK PHONE: _____ EXT : _____

CELLPHONE: _____ EMAIL ADDRESS: _____

ADDRESS: _____
Street Address & P.O. Box if Applicable City State Zip

EMPLOYER: _____ JOB TITLE: _____

EMPLOYMENT STATUS (Circle one): FT PT Retired Not Working Disability Self-Employed Homemaker Student

PRIMARY CARE PROVIDER: _____ PHONE: _____

REFERRING DOCTOR: _____ PHONE: _____

DATE OF (Circle One) INJURY / CONDITION / ACCIDENT : _____ DATE OF SURGERY: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

PRIMARY INSURANCE

WHAT IS YOUR PRIMARY HEALTH INSURANCE: _____

SUBSCRIBER'S NAME & RELATIONSHIP _____

ID# _____ GROUP# _____ SUBSCRIBERS DOB _____

SECONDARY INSURANCE

WHAT IS YOUR SECONDARY HEALTH INSURANCE: _____

SUBSCRIBER'S NAME & RELATIONSHIP _____

ID# _____ GROUP# _____ SUBSCRIBERS DOB _____

IS YOUR INJURY JOB RELATED & DO YOU HAVE AN OPEN CLAIM? YES NO CLAIM # _____

EMPLOYER: _____ CLAIMS MANAGER: _____ PHONE: _____

BILLING ADDRESS FOR SELF-INSURED COMPANIES: _____

IS YOUR INJURY DUE TO A MVA? YES NO THAT OCCURRED IN: _____ ARE YOU COVERED BY PIP*? YES NO

AUTO POLICY HOLDER: _____ CLAIM # _____
STATE

PIP ADJUSTER: _____ PHONE: _____

PIP BILLING ADDRESS: _____

For those with DSHS insurance

DSHS COVERS 6 THERAPY VISITS PER CALENDAR YEAR. HAVE YOU RECEIVED PT THIS YEAR? YES ___ NO ___

PLEASE SEE REVERSE SIDE

