PHYSIOTHERAPY

Active Rehab

MVA

PATIENT INFORMATION

Today's Date _________________ Date of Birth (mm ___ dd ___ yyyy ____) M__ F__
Name (Last) _________________________________(First) _________________________________
Street Address ____
City ___________________________ Postal Code _________________
Phone # (home) _______________(cell #)________________(work #) ______________
Emergency Contact: (name) _____________________(phone #) ____________________
E-mail: _____________________________________

FAMILY PHYSICIAN

Name ____________________________ Phone # ________________________

LAWYER/ LEGAL REPRESENTATION INFORMATION

Name: ___________________________ Phone # ________________________

EMPLOYER INFORMATION

Company Name __________________________ Occupation ______________________
Phone # ____________________________

EXTENDED HEALTH CARE INFORMATION

1ST Insurance company name ____
Policy # __________________________ Id #___________________________________
Policy holder name ______________________ Date of Birth _____________________

2nd Insurance company name ____
Policy # __________________________ Id #___________________________________
Policy holder name ______________________ Date of Birth _____________________

I am covered under only one insurance policy ____ Signature ___________________
I am covered under a secondary insurance policy ____ Signature___________________

AUTO INSURANCE

Insurance company name _____________________________
Date of Accident ________________Policy # _________________ Claim # __________
Adjuster name _______________________ Phone# _______________ Fax # __________

For Office Use Only

1st- PHYSIO :	MASSAGE :	ORTHOTICS : (Dispensed by Physio?_____)		TENS:
Yr Max-________	Yr Max-________	INSERTS: __________	SHOES: ___________	Yr Max-________
Visit Max-_______	Visit Max-_______	Max per yr-_________	Max per yr-______	%-____________
%-_________	%-___________	%-_________	%-________	Doc Ref-_______
Doc Ref -________	Doc Ref-________	Doc Ref-________	Doc Ref-_________	Estimate-______
Validity -________	Validity-_________	Validity-________	Validity-_________	Validity-_______

DEDUCTIBLE:	DIR PAY:	BEN YR:	SUB EXP:	MAILING ADDRESS:	SPOKETO/TIME/DATE:
Ind____ Fam____	Y___N___	_______	_________	____________________	_____________________