



Biographical Information

PATIENT INFORMATION

Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: Male Female

Marital Status: Married Divorced Single

Employer: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____

INSURED INFORMATION

Name: _____

Employer: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Relation to Patient: _____

Phone #: (Work) _____ (Home) _____

INSURANCE POLICY

Primary Insurance Name: _____

Policy #: _____ Group #: _____

Secondary Insurance Name: _____

Policy #: _____ Group #: _____

Date of Injury (If no injury occurred, please estimate start of current symptoms): _____

If your symptoms are the result of an injury, how did the injury occur: _____

During the course of treatment what is the best way to contact you for appointment verification or to determine current status:

Please check one: Email Home Phone Work Phone Other: _____

Is this injury the result of a motor vehicle accident? Yes No

If Yes, how are you filing: Auto Insurance Medical Insurance Self-Pay Through a Third Party

Did this injury occur at work? Yes No

If Yes, was the injury reported and filed under Workman's Compensation Yes No

If Yes, please list the name of your adjuster or contact for worker's compensation: _____

Phone #: _____ Ext: _____ Case Manager: _____

Phone #: _____ Ext: _____

Have you sought the assistance of an attorney, as a result of these injuries? Yes No

If Yes, please complete the following information: Attorney's Name: _____

Name of Firm: _____ Phone #: _____ Ext: _____

Emergency Contact

Name: _____ Daytime Phone: _____ Relation: _____



Assignment of Benefits / Consent for Treatment:

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

Assignment of Benefits/ Consent for Treatment:

I do hereby assign all medical benefits for which I am entitled including all government and private insurance plans to this office. This assignment shall remain in effect until revoked by me in writing. I understand that I am responsible for all my charges not paid by my insurance. I authorize this office to release all information necessary to secure payment, transit and process claims electronically or through any other reasonable and customary means; including but not limited to Medicare. I hereby voluntarily consent to my treatment at this office and authorize such treatments and procedures as determined medically necessary by my physician and rehabilitation specialist. I have read this consent, am aware of its contents and fully understand the same, affirmed by the signature of the undersigned:

Patient Signature: _____ Date: _____

Guardian: _____ Date: _____