

FACILITY NAME: _____ ACCOUNT #: _____ YEAR 2009

DATE OF APPT: _____ TIME: _____ Therapist Name: _____ Script Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

DATE RETIRED: _____ DOB: _____ Soc Sec #: _____ Sex: M F

Relationship to guarantor: Self Spouse Child Other Date of accident/onset: _____

EMAIL ADDRESS: _____ Work phone #: _____

Patient's employer: _____ Employer address: _____

Emergency Contact Name and Phone #: _____ How did you hear about us? _____

Patient Status: [] single [] employed [] married [] student FT [] student PT [] other

Condition related to:

[] Employment DOI: _____ Injury reported to employer? Y N

Town where injury occurred: _____

Employer at the time of injury: _____

How did injury occur? _____

[] Auto accident DOI: _____ NF application filed with carrier? Y N

Name of policy holder if not patient: _____

[] Other accident DOI: _____ [] None *****Being seen by Chiropractor? Y N

Referring Physician: _____ UPIN #: _____ Phone #: _____

Primary Physician: _____ UPIN #: _____ Phone #: _____

	Diagnosis/ICD-9	Specialty (PT, OT, SP)
1.	_____	_____
2.	_____	_____

Have you had treatments at another facility this year? Y _ N _

PRIMARY INSURANCE INFORMATION:

Subscriber's Name: _____ SS#: _____ DOB: _____

Phone #: _____ DATE RETIRED: _____ Employer: _____

Insurance Carrier: _____ Employer Address: _____

Billing address: _____ Phone #: _____ Fax #: _____

Certificate #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Subscriber's Name: _____ SS#: _____ DOB: _____

Phone #: _____ DATE RETIRED: _____ Employer: _____

Insurance Carrier: _____ Employer Address: _____

Billing address: _____ Phone #: _____ Fax #: _____

Certificate #: _____ Group #: _____

I hereby authorize the facility to provide treatment and services to myself and/or above named patient. I also authorize the release of any and all necessary information to my insurance carrier(s) for direct processing by the facility or affiliated agent (or agency) of the facility. I further authorize the facility to pursue via Insurance Commission or other agencies, payments for therapy treatments within the state mandated time limitations. **Copayments are expected at the time of visit.**

SIGNATURE _____

DATE: _____

Parent or guardian if patient is under 18 yrs old.