

Sport and Spine Physical Therapy, Inc.

PATIENT INFORMATION

Date _____

Referring Doctor _____ Phone Number _____

Primary Care Doctor _____ Phone Number _____

Last Name _____ **First** _____ **M.I.** _____

Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Work Phone Number _____ SS# _____

Date of Birth _____ Sex M ___ F ___ Drivers License # _____

Marital Status: M ___ S ___ D ___ Spouse's Name _____

Is this a work related injury? Yes _____ No _____ Date of Injury _____

Is this an auto accident related injury? Yes _____ No _____ Is there an attorney involved Yes _____ No _____

PATIENT WORK INFORMATION

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Work Phone Number _____ Extension _____

Employee Id Number _____ Occupation _____

PRIVATE INSURANCE INFORMATION

Is this your coverage Yes ___ No ___ If no, whose name is covered _____ DOB _____

Your relationship to the insured _____ Policy Number _____

Group Number _____ Certificate Number _____

Insurance Company Name _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

Sport and Spine Physical Therapy, Inc.

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship _____
Insurance Policy Number _____ Group Number _____
Insurance Company Name _____ Phone # _____
Ins. Co. Address _____
City _____ State _____ Zip Code _____

AUTO INSURANCE INFORMATION

Name of Insured _____
Auto Insurance Company Name _____
Address _____
City _____ State _____ Zip Code _____
Policy Number _____ Claim Number _____
Adjustor's Name _____ Phone Number _____

WORKER'S COMPENSATION INFORMATION

Employers Name (at time of injury) _____
W/C Insurance Name _____ Phone# _____
Address _____
City _____ State _____ Zip Code _____
Claim Number _____ Case Manager Name _____
Case Manager phone number _____

ATTORNEY INFORMATION

Name _____ Phone # _____
Address _____
City _____ State _____ Zip Code _____

AUTHORIZATION TO PAY ANY PHYSICAL THERAPY

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to **Sport and Spine Physical Therapy, Inc.** and I am financially responsible for non-covered services. I also authorize **Sport and Spine Physical Therapy, Inc.** to release any information to process this claim.

SIGNED: _____ DATE _____