PATIENT INFORMATION

Left column	Right column
Date: ACCT #:	☐ NP ☐ UPDATE ☐ WC Staff Initials:
NAME	**PRIMARY INSURANCE**
Last: First: MI:	Name:
Address:	Policy Number: Group No:
City:	Policy Holder's Name:
State: ZIP:	Policy Holder's Employer:
DOB:	PH SS: DOB:
Telephone: Cell Phone:	**SECONDARY INSURANCE**
Work Phone:	Name:
☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Policy Number: Group No:
SS: Age:	Policy Holder's Name:
Email:	Policy Holder's Employer:
Ordering Physician:	PH SS: DOB
Address	PH Phone:
City: State: Zip:	**REASON FOR VISIT**
Telephone: Fax:	Date of 1st Symptom:
PARENT/GUARDIAN (If Patient is under 18)	On the Job Injury? Y/N Previous Injury? Y/N
Name: SS:	Date of Injury: Time of Injury:
Employer Address:	Motor Vehicle Accident? Y/N Other Accident? Y/N
City: State: Zip:	What US State did Accident Occur?
Telephone:	Date of Accident: Time of Accident:
Home Address	Body Area Affected:
City: State: Zip:	Date of Surgery (If Applicable):
Relationship to Patient: DOB:	Other:
	How did you hear about our practice?
	☐ Doctor ☐ Case Manager ☐ Insurance ☐ Friend/Relative
	☐ Other:

PATIENT INFORMATION

ATTORNEY INFORMATION

Name:

Address:

City: State: Zip:

Telephone: Fax:

EMERGENCY CONTACT INFO

Last: First: MI:

Address:

City: State: Zip:

Telephone: Email:

Auto Accident Information

Insured Party:

Ins. Company Policy #

Claim # Adjuster:

Date Accident reported to Ins:

IF OTHER DRIVER AT FAULT

Name:

Ins. Company Policy #

Claim # Adjuster:

Date Accident reported to Ins:

PATIENT EMPLOYER

Name: SS:

Address

City: State: Zip:

Occupation: Telephone:

CONSENT TO TREAT

I hereby authorize treatment for myself or the above mentioned patient (if a minor) by:

The Therapy Network

Signature____

Date:___________________________

Dr Edward Walko

Signature____

Date:___________________________

Dr Garrett Kelly

Signature____

Date:___________________________

Dr Ronald Gaylon

Signature____

Date:___________________________

WC Claim Information

Claim #:

Adjuster:

Telephone: Fax:

Case Manager:

Telephone: Fax:

Carrier: Phone:

Address:

City: State: Zip:

Employer Contact:

PATIENT BENEFITS AGREEMENT

The Therapy Network has made a good faith effort to obtain your authorization and/or benefits for outpatient physical therapy at this facility. Authorization or verification of benefits is not a guarantee of payment Any information obtained is based on your specific policy guidelines. If you have questions on your benefits, please contact your insurance representative. I have read and understand this statement: ____