THE PHYSICAL THERAPY INSTITUTE℠
ORTHOPEDICS AND SPORTS MEDICINE

NAME: _____ DOB: _____/_____/_____

ADDRESS: _____ GENDER: M F

_____ SS#: _____-_____-_____

HOME PHONE: _____ PHYSICIAN: _____

WORK/CELL: _____ PHYSICIAN PHONE #: _____

Email: _____

INSURANCE

PRIMARY: _____ SECONDARY: _____

POLICY/CLAIM#: _____ POLICY/CLAIM#: _____

GROUP#:_____ GROUP#_____

SUBSCRIBER: SELF SPOUSE PARENT SUBSCRIBER: SELF SPOUSE PARENT

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____/_____/_____ SUBSCRIBER DOB: _____/_____/_____

***HAVE YOU RECEIVED HOME HEALTH IN THE PAST 6 MONTHS:** **YES** **NO**

***HAVE YOU RECEIVED CHIROPRACTIC TREATMENT IN THE LAST YEAR:** **YES** **NO**

***IS THIS A WORK INJURY:** **YES** **NO** **EMPLOYER:** _____

***IS THIS AN AUTO INJURY:** **YES** **NO** **STATE THAT ACCIDENT OCCURRED IN:** _____

PATIENT: I HAVE REVIEWED THE ABOVE INFORMATION AND IT IS CORRECT: YES NO Initials: _____

OFFICE USE ONLY: APPOINTMENT: DAY:_____DATE: _____/_____/_____ TIME: _____

Effective Date:__/__/__ Benefit Year:___/___/___to___/___/___ Effective Date:__/__/__ Benefit Year:___/___/___to___/___/___

Copay: _____Coin:_____Ded_____ met?_____ Copay: _____Coin_____Ded_____met?_____

AUTH: □None □Now - Tmt Plan Y N □Later – After visit #_____ AUTH: □None □Now - Tmt Plan Y N □Later – After visit #_____

VISIT LIMIT: □None □per cap □_____per calendar/benefit year VISIT LIMIT: □None □per cap □_____per calendar/benefit year

VERIFIIED: _____/_____/_____ BY: _____ *If Medicare supplement, pays Part B Coin Y N Ded Y N

Comments_____

Type of Insurance: □BC □Commercial □WC □Auto □Medicare □Medicare Supplement □Self

PHYSICAL THERAPIST: Date of Injury: _____/_____/_____

Dx. Codes: 1)_____ 2)_____ 3)_____ 4)_____