



DATE & INITIAL: \_\_\_\_\_

**PATIENT INFORMATION PRIVATE/MEDICARE**

Chart Number \_\_\_\_\_

Location \_\_\_\_\_

Diagnosis/Body Part: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(First, Middle, Last)

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Drivers License: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Dx. \_\_\_\_\_ Dx. \_\_\_\_\_ Dx. \_\_\_\_\_ Dx. \_\_\_\_\_

Billing Therapist \_\_\_\_\_

Date of Appt./ time: \_\_\_\_\_

D.O.I: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: S M W D

Sex: M F

Date Last Seen \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company/Type: \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Called Insurance: Date/Time/Name \_\_\_\_\_

Deductible: \_\_\_\_\_ Deductible met: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Approved visits/max: \_\_\_\_\_

Claims Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured Name (Different from patient) \_\_\_\_\_

Insured Phone \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Plan Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Out of Pocket: \_\_\_\_\_ Met: \_\_\_\_\_

Copay/co. ins. \_\_\_\_\_

Rx necessary: \_\_\_\_\_

Ins. Phone #: \_\_\_\_\_

Ins. Fax #: \_\_\_\_\_

In Network? SFSSPT: \_\_\_\_\_, SM: \_\_\_\_\_

Insured SS# \_\_\_\_\_

Insured Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Effective Date: \_\_\_\_\_ Approved visits/max: \_\_\_\_\_

Called Ins: Date/Time/Name \_\_\_\_\_

Coverage: \_\_\_\_\_

Insured Name (Different from patient) \_\_\_\_\_

Insured SS# \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Insured Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Plan Name: \_\_\_\_\_

Group #: \_\_\_\_\_

Ins. Phone #: \_\_\_\_\_

Ins. Fax #: \_\_\_\_\_

Rx Necessary: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

UPIN: \_\_\_\_\_

Phone #: \_\_\_\_\_

RX: Yes/No – RX Date: \_\_\_\_\_

Specialty: \_\_\_\_\_