Insurance Information

(Complete the section below that applies)

Patient Name: _____

Patient Birth Date: ___ /___/_____ Age: _____

Insured Party: □ Self □ Spouse □ Child □ Mother □ Father □ Other _____

Primary Medical Insurance

□ Check if you have provided us with a copy of your Insurance Card

Insurance Company: _____

ID Card #: _____ Group #: _____

Guarantor Name: _____

Guarantor's Birth Date: ___ /___/_____

Guarantor's Address (if different from patient): Street: _____

City: _____ State: _____ Zip: _____

Labor & Industries/ Worker's Comp Insurance

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Occupation/ Job Title: _____ Job Description: _____

Claim #: _____

Claim Manager: _____ Claim Manager Ph Number: _____

Is claim open? □YES □NO □UNKOWN

Have you had previous physical therapy under this claim? □YES □NO

Auto Accident Insurance

Auto Insurance Company: _____ Date of Accident: _____

PIP Coverage? □YES □NO (If no, please complete attorney section)

Policy #: _____ Claim #: _____

Adjuster Name: _____ Phone: _____

If PIP coverage not available:

Attorney Name: _____ Phone: _____