

# PATIENT INFORMATION

Clinic \_\_\_\_\_ Case Number \_\_\_\_\_ Date First Seen \_\_\_\_\_  
(Month/Date/Year)  
Patient Name \_\_\_\_\_ Diagnosis Code \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_  
(Month/Day/Year) (Male/Female)  
Home Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
(Area Code) (Area Code)  
E-mail Address \_\_\_\_\_ School if Student \_\_\_\_\_  
Patient Employer \_\_\_\_\_ Position \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone # \_\_\_\_\_  
(Street) (City, State, Zip) (Area Code)  
Referral Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
(Area Code)  
Treatment Area \_\_\_\_\_ Injury Date \_\_\_\_\_ Surgery Date \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)  
**Due to Auto Accident:** Yes/No **Injury at Work:** Yes/No **Third Party Accident:** Yes/No **Sports Injury:** Yes/No  
Attorney \_\_\_\_\_  
(Name) (Street) (City, State, Zip) (Phone #)

## EMERGENCY CONTACT

Spouse/Parent/Friend \_\_\_\_\_  
(Circle One)  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer \_\_\_\_\_ Position \_\_\_\_\_  
Employer Address \_\_\_\_\_ Phone # \_\_\_\_\_

## INSURANCE INFORMATION

**PRIMARY** Company Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber DOB \_\_\_\_\_

**SCNDARY** Company Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber DOB \_\_\_\_\_

## VERIFICATION

Date \_\_\_\_\_ Talked To \_\_\_\_\_ Phone # \_\_\_\_\_ Effective Date \_\_\_\_\_  
(Month/Day/Year) (Area Code) (Month/Day/Year)  
Visit Limit Per Year \_\_\_\_\_ Insurance Pays \_\_\_\_\_ Deductible/Year \_\_\_\_\_ Amount Met \_\_\_\_\_  
Copay/Visit \_\_\_\_\_ Out-of-Pocket Met: YES/NO Amnt Met \_\_\_\_\_ Ins. Plan Referral Required: YES / NO  
Any Limitations/Exclusions: YES / NO What are they? \_\_\_\_\_  
Authorization Required: YES / NO Auth # \_\_\_\_\_ Verified By \_\_\_\_\_

1. I authorize the release of any medical information necessary to process this claim as well as to my physician(s).
2. I request payment of Government Benefits either to myself or to the party who accepts assignment.
3. I also authorize payment of medical benefits to the Physical Therapy provider for services described.
4. I consent to treatment and/or examination under the supervision of my attending Therapist.
5. I have received Excel Physical Therapy's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's or Authorized Person's Signature  
(Read Before Signing)

\_\_\_\_\_  
Date