Referred by	Date

PATIENT INFORMATION

Name:	Date of Birth:
Address: May I mail to this address?	
Telephone No (wk) (home) (cell)	SS#
E-mail address May I e-mail to this address?	Which number may I leave message on? Circle those
Nearest Relative	Telephone
Address	
Patient's Employer	
Address	Telephone
Spouse's Name	SS#
Spouse's Employer	
Address	Telephone
Purpose of Visit	
Have you seen this type of therapist before?	
Is Illness/Injury work related? _____yes _____no *If yes, please complete the next section*	
Employer Address	
Address	Telephone
Date of Accident / Contact	
Patient's Ins. Carrier/Firm Group Worker's Comp Individual Other	
Address	Telephone
Insured Party	Group/Policy#
SS# / Contact/Adjuster	
Please list any medication you are taking and doses	

AUTHORIZATION TO PAY PHYSICIANS

I hereby authorize payment directly to the physician by signing this form, the medical benefits otherwise payable to me but not to exceed the charges incurred. I understand that I am financially responsible to the physician for charges not covered by my policy. I hereby authorize medical information to be released to the insurance company for processing this claim.

*Date*_____ *Signature of Insured*_____