Lim physical therapy

PATIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____
Address: _____City:_____ State:_____ Zip:_____
Hm Ph: (_____) _____ Wk Ph: (_____)_____Cell Ph: (_____)_____
Email Address: _____
Birthdate: _____/_____/_____ Sex: M F
Emergency Contact: _____ Phone: (_____)_____
Marital Status: M S D W Other Spouse/Guardian Name:_____
Employer:_____School:_____

PRIMARY INSURANCE INFORMATION

(Leave blank if you've provided your insurance card)
Primary Insurance:_____ Phone:_____
Policy/Claim/ID#:_____ Group #:_____
Adjuster : _____ Address: _____
City:_____State:_____Zip:_____

SUBSCRIBER INFORMATION

Relationship to Subscriber: (circle one) Self / Spouse / Parent / Other
Complete address if different from above
First Name:_____ Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Hm Phone:_____ Wk Phone:_____
Birthdate: _____/_____/_____ Sex: M F Social Security #:_____
Employer:_____
School:_____

OTHER INFORMATION

How did you hear about us? (Please circle) Family/Friend, Doctor, Web, Other _____
Family Doctor: _____ Referring Doctor: _____
Where did injury occur?:
Home:____ Work_____ School:_____ Sports:_____ Auto:____ No Accident: _____ Other:_____
Injury Date: _____/_____/_____
What part of the body are we treating? Right/Left:_____

I understand that I am directly responsible for all charges incurred. I authorize benefits to be paid directly to Lim Physical Therapy LLC. I am responsible for all non-covered charges.

Signed: _____ Date: _____