

Patient Name: _____ **Date:** _____

Phone # 1: _____ **Phone # 2:** _____ **DOB:** _____

May we leave messages at the above phone #s? Yes No

Social Security #: _____ **Referring Physician:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____

May we send balance information to this email? Yes No

Gender : Male Female **Marital Status:** Married Single Divorced

Employer: _____ **Spouse's Name:** _____

Employer's Address: _____ **Spouse's Employer:** _____

Employer's Phone: _____ **Spouse's Work Phone:** _____

Emergency Contact: Name: _____ **Phone #:** _____

Are your injuries due to an accident? Yes No **If yes, what kind of accident?** Auto Work Other

Date of Accident: _____ **Briefly describe accident:** _____

Primary Insurance (Please present insurance card and driver's license to receptionist)

Insurance Company: _____

ID#: _____ **Group ID #:** _____

Policy Holder's Name: _____ **DOB** _____ **SS#** _____

Deductible Amount: In Network: _____ Out of Network: _____

Deductible Met: In Network: _____ Out of Network: _____

Pt's Estimated Co-Ins. amount: In Network: _____ Out of Network: _____

Any Policy limits: Yes / No _____

Secondary Insurance

Insurance Company: _____

ID#: _____ **Group ID #:** _____

Policy Holder's Name: _____ **DOB** _____ **SS#** _____

Deductible Amount: In Network: _____ Out of Network: _____

Deductible Met: In Network: _____ Out of Network: _____

Pt's Estimated Co-Ins. amount: In Network: _____ Out of Network: _____

Any Policy limits: Yes / No _____

Your insurance has provided us with the above information. Ford Physical Therapy cannot guarantee payment of services. The patient is responsible for any unpaid balances. Insurance payments are based on medical necessity, even if coverage is at 100%.

Patient Date

Employee Date