CRAY PHYSICAL THERAPY

WELCOME TO OUR CLINIC

PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name________________________ Referring Physician________________________

Address________________________ City________________ State________ Zip________

Home Phone________________ Cell ________________ Primary Physician________________

Date of Birth____________ SS#______________ Sex________ Diagnosis________________

Employer________________________ Address________________________

City________________________ State______ Zip______ Phone________________

Emergency Contact________________________ Phone________________

Injury Result of Accident? Y or N Work Comp?________ Auto? ________ Date of Injury________________

Email Address____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Co. Name________________________

Address________________________

City____________ State______ Zip______

Phone #____________ Group#____________

ID #________________________

Subscriber (if other than patient) DOB____________

Name________________________

Relationship to patient-Spouse____ Parent____ Other____

Copay/Coinsurance________________

Benefit ________________________

SECONDARY

Insurance Co. Name________________________

Address________________________

City____________ State______ Zip______

Phone #____________ Group#____________

ID #________________________

Subscriber (if other than patient) DOB____________

Name________________________

Relationship to patient: Spouse____ Parent____ Other____

Copay/Coinsurance________________

Benefit ________________________

WORKMANS COMPENSATION INFORMATION

Insurance Co. Name________________________ Claim #________________________

Address________________________ City________________ State______ Zip________

Adjuster________________________ Phone________________ Ext________

Employer at the time of Injury________________________ Phone________________________

Address________________________ City________________ State______ Zip______

UR Phone________________________ UR Fax________________________

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name________________________ Claim #________________________

Address________________________ City________________ State______ Zip________

Adjuster________________________ Phone________________ Ext________

Name of Insured (if other than patient)________________________ Relationship________________

PIP Available? ____