A BETTER LIFE d/b/a ABLE PHYSICAL THERAPY

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WELCOME to our clinic! We hope to make your stay with us as pleasant as possible. In order to serve you to the best of our capabilities and to ensure your insurance, and not you, are billed for our services, please fill out the following in its entirety. We look forward to working with you to reach your therapy goals!

For office use only: ___ NEW PATIENT ___ EXISTING PATIENT (Change in info. Entered by ___)

TODAY'S DATE: _____/_____/_____ **(Entered into EMR by ___)**

(Insurance verified by ___)

PATIENT INFO

LAST NAME:	**FIRST NAME:**	**MIDDLE INTIAL:**
GENDER: Male / Female	**SS#**	**BIRTHDAY: / /**
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
TEL:	**FAX:**	**CELL:**
EMAIL:		**MARITAL STATUS:**
PRIMARY DOCTOR:		**DOCTOR'S TEL:**
DOCTOR'S ADDRESS:		

EMPLOYER INFO - Please fill in the following information about your present employer.

EMPLOYER NAME:		
ADDRESS:		
PHONE/EXT:	**FAX:**	**EMAIL:**
SUPERVISOR NAME AND TITLE (For Workers Compensation):		
YOUR OCCUPATION:		

RESPONSIBLE/INSURED PARTY INFO – If you are a minor or your spouse is the responsible insured party (guarantor), please fill in the following. If you are the insured and the info is the same as above, skip this section.

RESPONSIBLE PARTY'S LAST NAME:	**FIRST NAME:**	**MIDDLE INTIAL:**
RELATION TO YOU:	**SS#:**	**BIRTHDAY: / /**
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
TEL:	**WORK:**	**CELL:**
EMAIL:		**MARITAL STATUS:**
EMPLOYER NAME:		**GENDER: Male / Female**
ADDRESS:		
PHONE/EXT:	**FAX:**	**EMAIL:**

PRIMARY INSURANCE CARRIER INFO – please provide the following information for your primary health insurance carrier.

INSURANCE COMPANY NAME:	
NAME ON POLICY:	
INSURED'S SS#:	**INSURED'S BIRTHDAY: / /**
INSURANCE COMPANY ADDRESS:	
POLICY/MEMBER ID#	**GROUP #**
ADJUSTER NAME:	**EMAIL:**
PHONE:	**FAX:**

SECONDARY INSURANCE CARRIER INFO – please provide the following information for your primary health insurance carrier.

INSURANCE COMPANY NAME:	
NAME ON POLICY:	
INSURED'S SS#:	**INSURED'S BIRTHDAY: / /**
INSURANCE COMPANY ADDRESS:	
POLICY/MEMBER ID#	**GROUP #**
ADJUSTER NAME:	**EMAIL:**
PHONE:	**FAX:**

WORKERS COMPENSATION OR MOTOR VEHICLE ACCIDENT/PERSONAL INJURY INFO – please provide the following information as it pertains to you.

WC/AUTO INSURANCE COMPANY NAME:	
CLAIM #:	
POLICY #:	**DATE OF INJURY: / /**
INSURANCE COMPANY ADDRESS:	
ADJUSTER'S NAME:	**EMAIL:**
PHONE:	**FAX:**
CASE MANAGER'S NAME:	**EMAIL:**
PHONE:	**FAX:**
ATTORNEY'S NAME:	**EMAIL:**
PHONE:	**FAX:**
ATTORNEY'S ADDRESS:	
MVA/PIP PLS CIRCLE ONE: Driver / Passenger / Pedestrian / Public Vehicle / Slip and Fall / Other	

DO YOU HAVE A PRESCRIPTION? _____

WHO MAY WE THANK FOR REFERRING YOU TO US? HOW DID YOU HEAR ABOUT US? PLEASE INCLUDE FULL NAME AND ADDRESS OF YOUR REFERRAL SOURCE (DOCTOR, ATTORNEY, PATIENT, ETC).

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