



Personalized PT
P.C.

Get Better

PATIENT INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

SOC. SEC#: _____

EMPLOYER: _____

GENDER: M F

ADDRESS: _____

MARITAL STATUS: _____

REFERRING PHYSICIAN: _____

WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

INSURED NAME: _____

RELATIONSHIP _____

POLICY #: _____

GROUP #: _____

PLAN NAME: _____

INSURED DATE OF BIRTH: _____

INSURED ADDRESS: _____

INSURED WORK: _____

INSURED PHONE: _____

OFFICE CO-PAY: _____

DEDUCTIBLE: _____

WORKERS COMPENSATION: Y N

AUTO ACCIDENT: Y N

SECONDARY INSURANCE COMPANY: _____

INSURED NAME: _____

RELATIONSHIP _____

POLICY #: _____

GROUP #: _____

PLAN NAME: _____

INSURED DATE OF BIRTH: _____

INSURED ADDRESS: _____

INSURED WORK: _____

INSURED PHONE: _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Personalized PT, PC, for any services furnished to me by Personalized PT, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or other insurance companies and their agents any information needed to determine these benefits payable for related services.

Signature of Beneficiary

Date

FOR OFFICE USE ONLY

Dx Code: _____ Dx: _____ DLS: _____

Please bring this form with you, or FAX it to 802.253.6852