CAMELVIEW PHYSICAL THERAPY

PATIENT INFORMATION SHEET – PLEASE FILL OUT COMPLETELY

PATIENT' S NAME (LAST)		(FIRST)			(MIDDLE INITIAL)	SOCIAL SECURITY #
DATE OF BIRTH	GENDER	SEX	MARITAL STATUS	AGE	EMAIL ADDRESS	
STREET ADDRESS(PRESENT)			CITY,STATE,ZIP			CURRENT PHONE NUMBER
STREET ADDRESS(PERMANENT)			CITY,STATE,ZIP			CELL PHONE NUMBER
PATIENTS EMPLOYER		OCCUPATION	WORK PHONE NUMBER/ EXT			DRIVERS LICENSE # / STATE
REASON FOR PHYSICAL THERAPY VISIT			REFERRING DOCTOR			PRIMARY CARE DOCTOR

SPOUSE(OR PARENTS) NAME	EMPLOYER	SOC SECURITY #	BIRTH DATE	WORK PHONE/EXT
EMERGENCY CONTACT/RELATIONSHIP	STREET ADDRESS			PHONE NUMBER / EXT

IF YOUR INJURY IS WORK RELATED (INDUSTRIAL) PLEASE FILL IN BELOW:

INDUSTRIAL INSURANCE COMPANY	EMPLOYER AT TIME OF INJURY	DATE OF INJURY	CLAIM NUMBER
INDUSTRIAL INSURANCE ADDRESS	PHONE NUMBER		NAME OF ADJUSTER/CASE MGR

IF YOUR INJURY IS NON-INDUSTRIAL, PLEASE FILL IN BELOW:

PRIMARY INSURANCE COMPANY	POLICY OR MEDICARE NUMBER		GROUP NUMBER	EFFECTIVE DATE	CO-PAY AMT
POLICY HOLDER'S NAME	RELATIONSHIP TO YOU	GENDER	DATE OF BIRTH	EMPLOYER	
SECONDARY INSURANCE COMPANY	POLICY OR MEDICARE NUMBER		GROUP NUMBER	EFFECTIVE DATE	CO-PAY AMT
POLICY HOLDER'S NAME	RELATIONSHIP TO YOU	GENDER	DATE OF BIRTH	EMPLOYER	

IF YOUR INJURY IS FROM AN AUTO ACCIDENT OR OTHER THIRD PARTY, PLEASE FILL IN BELOW:

DATE OF INJURY	NAME OF ATTORNEY	ADDRESS OF ATTORNEY	ATTORNEY'S PHONE NO.
NAME AND ADDRESS OF INSURANCE COMPANY (IF APPLICABLE)		INSURANCE PHONE NUMBER	EXTENSION
CLAIM NUMBER	ADJUSTER		RESPONSIBLE PARTY

AUTHORIZATION: I request that payment of authorized Medicare or other benefits be made either to me or on my behalf to Camelview Physical Therapy, Inc. for any services furnished me by that physical therapist, massage therapist or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physical therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. Photocopies of this form are as valid as the original.

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PATIENT SIGNATURE **DATE**

_____ _____

SIGNATURE OF PARENT OR GUARDIAN OF MINOR **DATE**