Stockwell
PHYSICAL THERAPY

Patient Information

Last Name: ____________________ **First Name:** _______________ **Middle Initial:** __________

Address: ___________________________ **City, State, Zip:** _______________________________

Home Phone: ______________ **Work Phone:** _________________ **Cell Phone:** ______________

Email: ____ **Fax:** _______________________________

Birth Date: ________________ **Sex:** Male or Female **SS#:** ____________________________

Employer: _____________________ **Occupation:** ____________________ **Work Status:** FT/PT

How were you referred (i.e. yellow pages, MD, friend, etc)_____________________________

Emergency Contact: _____________________ **Relationship:** ________ **Phone:** _________

Insurance Information

Primary Insurance Information:

Name of the Policy Holder: ____

DOB of Policy Holder: _______________ **Relationship to Patient** _______________________

Policy Number: _________________________**Group Number:** ___________________________

Name of Insurance Company: ____

Address of Insurance Company: _____________________**State:** ________**Zip:** _____________

Secondary Insurance Information:

Name of the Policy Holder: ____

DOB of Policy Holder: _______________ **Relationship to Patient** _____________________

Policy Number: ______________________**Group Number:** _______________________

Name of Insurance Company: ____

Address of Insurance Company: _____________________**State:** ________**Zip:** ____________

Insurance Verification Information **(office use only)**

Date Verified: ______________ Method**:** Website or Phone

Maximum # of Visits: _______________ Maximum **Amount: $** _____________________

In Network: Deductible _________________ Copay: ________________

Out of Network: Deductible _____________ Copay: ________________

 # Of Visits Authorized: ______________ **Auth Date Range:** _________________________

Authorization #: ____

Comments____