



PATIENT INFORMATION

Patient's Full Name: (First) _____ (Middle) _____ (Last) _____

Home Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Male _____ Female _____ Date of Birth: _____ Marital Status: _____

Patient's Employer: _____ Work Phone: _____

Employers

Address

Occupation: _____

Who referred you to our facility? _____

BILLING INFORMATION

Name of Insurance Company: _____

Name of Subscriber: _____ Relationship to Patient: _____

ID # _____ Group# _____ Billing Address: _____

City: _____ State: _____ Zip Code: _____

If the insurance subscriber (policy holder) is not the patient, please complete:

Social Security #: _____ Date of Birth: _____ Employer: _____

REASON FOR VISIT INFORMATION

Is this due to an injury: Yes _____ No _____

If yes check one: Auto Accident _____ On the job injury _____ Other _____

Urban Physical Therapy, Inc. will file insurance for all reimbursable services to both primary and secondary insurance carriers. Please remember you are responsible for all deductibles, co-pay, and non covered service amounts on the date of service. By signing this form, I agree to be responsible for any fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim. I authorize payment of benefits to Urban Physical Therapy, Inc.

Signature of patient or responsible party

Date