ADVANCED THERAPY & SPORTS MEDICINE, CHTD.

Date:_____________________________

Account #________________________

Referring Physician:_______________________

Date of Script:_____________________________

Social Security #____

E-mail address:____________________________

(Internal use only)

PATIENT NAME :____

(Last) (First) (Initial)

ADDRESS:____

____

(City) (State) (Zip)

PHONE: (HOME) _( )______-_________________________(WORK) _ ( )______-______________________

BIRTHDATE:______________________SEX:____M_____F **MARITAL STATUS**:___M___S___D___W

SPOUSE:_____________________________________**DAYTIME PHONE:**________________________________

PATIENT'S EMPLOYER:____**OCCUPATION:**_____________________

ADDRESS:____

EMERGENCY CONTACT (NOT RESIDING WITH YOU)

NAME:____**PHONE** ( ) -

ACCIDENT DETAILS / REASON FOR VISIT (REQUIRED FOR INSURANCE FILING)

We will need to copy the front and back of your insurance cards for billing purposes, and to verify coverage. If SELF PAY, you will need to make payment arrangements at your initial appointment. Workers Compensation claims require authorization from the employer or insurance carrier.

WHAT TYPE OF ACCIDENT? (CIRCLE ONE): NONE AUTO WORK OTHER

DATE OF INJURY/ACCIDENT:______________________ **BODY PART**:____

DETAILS OF ACCIDENT/INJURY:____

____

SURGERY:_______**Y**_______**N** **DATE OF SURGERY**_______________________________________

RESPONSIBLE PARTY (***PRIMARY PERSON ON INSURANCE IF DIFFERENT THAN PATIENT***)

RELATIONSHIP TO PATIENT:______SPOUSE__________PARENT___________OTHER

NAME:____

ADDRESS:____

CITY:____STATE:____________ZIP:______________

HOME PHONE(_______)_______________________________WORK PHONE (_______)_____________________________

SOC SEC #____SEX_______M_______F BIRTHDATE_______________________

EMPLOYER:____

STREET ADDRESS:____

CITY:____STATE:_____________ZIP:______________________