"Hands on Healing, A Passion for Performance"

PATIENT INFORMATION

Last Name ______________________ First ______________________ M.I __________

Address ______________________________________ City: ______________________

State __________ Zip Code ____________ Email ______________________________

Home Number: ________________ Cell: ______________ Work: ______________

Date of Birth ________________ Sex: **M** _____ **F** _____ SS# ______________________

Marital Status **M** _____ **S** _____ **D** _____ Spouse's Name: ___________________________

Have you ever been a patient at Lodi Physical Therapy or the PUMP Institute? **Yes** _____ **No** _____ When ____________

How did you hear about our clinic? ____

In case of emergency, please contact: ____________________ ***Phone Number:*** ______________

SUBSCRIBER INFORMATION

Employer's Name ____

Employer's Address ____

City ____________________ State ____________ Zip Code ________________

Work Phone Number ____________________ Occupation ______________________

MEDICARE INFORMATION

Medicare Number (if applicable) ______________________________________

PRIMARY INSURANCE INFORMATION

Is this your coverage? **Yes** _______ **No** _______ If no, whose name is covered? ____________________

Relationship to subscriber ____________________ Subscribers Date of Birth ______________

ID Number __________________________ Group Number ____________________

Insurance Company Name ____

Address ____

City ____________________ State ____________ Zip Code ________________

Phone Number ________________________

Continued →→→

SECONDARY INSURANCE INFORMATION

Is this your coverage? **Yes** ________ **No** ________ If no, whose name is covered? ____

Relationship to subscriber ____ Subscribers Date of Birth __________________________

ID Number ____ Group Number ____________________________________

Insurance Company Name ____

Address____

City _________________________________State _________________ Zip Code_____________________________

Phone Number ____

WORKERS' COMPENSATION INFORMATION

Is this a work related injury? **Yes** ______ **No** ______ Date of Injury____________________________________

Employer's Name (at time of injury) ____

W/C Insurance Name ______________________________________Phone # ____

Address ____

City ______________________________________State _________________ Zip Code____________________________

Claim Number ____ Adjustor's Name ____

AUTO INSURANCE INFORMATION

Is this an auto accident injury? **Yes** _______ **No**_______ Is there an attorney involved? **Yes** _______ **No** _______

Name of Insured____

Auto Insurance Company Name __________________________________ Address ____

City___________________________________State____________________Zip Code __________________________

Policy Number ______________________________________Claim Number ____

Adjustor's Name ____ Phone Number ______________________________________

ATTORNEY INFORMATION

Name ____ Phone # _______________________________________

Address ____

City __________________________________ State _________________ Zip Code ____________________________

AUTHORIZATION TO PAY LODI PHYSICAL THERAPY and the PUMP Institute

I hereby authorize my insurance benefits to be paid directly to LODI PHYSICAL THERAPY or the PUMP Institute, and I am financially responsible for the non-covered services. I also authorize LODI PHYSICAL THERAPY and the PUMP Institute to release any information to process this claim.

SIGNED____**DATE** _________________________