Therapy Solutions

TAKE YOUR LIFE BACK.

Date: __________

How did you hear about Therapy Solutions? ____

PATIENT INFORMATION ***PLEASE PRINT NEATLY***

Patient Name__________________________________ Date of Birth_______________ Age ____ ☐ Male ☐ Female

Home Address_________________________________ City____________________ State______ Zip____________

Billing Address_________________________________ City____________________ State______ Zip____________

Home Phone_________________________ Work_________________________ Cell__________________________

Social Security Number__________________________ Email Address______________________________________

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer _______________________________________ Occupation ______________________________________

Emergency Contact ______________________________ Relationship_____________ Phone___________________

Referring Physician ______________________________ Primary Physician (PCP) ____________________________

Area of Injury (Body part) ____________________________________ Date of Injury ___________________________

Are you receiving home health care? ☐ YES ☐ NO Date of Surgery_________________________

Is this injury the result of an accident? ☐ YES ☐ NO If yes: ☐ Work Comp ☐ Auto Accident

HEALTH INSURANCE INFORMATION

1. Primary

Insurance Company Name ______________________________________ Phone ____________________________

Address _______________________________________City ___________________ State_____ Zip _____________

I.D. # ____ Group # _____________________________________

Subscriber Name (If other than patient) __________________________________ Date of Birth _________________

Relationship to patient _____________________________

Address____ Phone Number _____________________________

☐ Check if address and phone number is same as the patient's information above

2. Secondary

Insurance Company Name ______________________________________ Phone ____________________________

Address _______________________________________City ___________________ State_____ Zip _____________

I.D. # ____ Group # _____________________________________

Subscriber Name (If other than patient) __________________________________ Date of Birth _________________

Relationship to patient _____________________________

Address____ Phone Number _____________________________

☐ Check if address and phone number is same as the patient's information above

WORKFORCE SAFETY AND INSURANCE

Claim # ____________________________________

Employer at the time of injury ____ Phone _______________________

Address _____________________________________ City _____________________ State ______ Zip ___________

AUTOMOBILE INSURANCE INFORMATION

Insurance Company Name ____________________________________ Claim # _____________________________

Address _______________________________________ City _____________________ State _____ Zip ___________

Name of Insured (If other than the patient) ____

Place (State) Accident Occurred In _____________________________

Adjustor _______________________________________ Phone ___________________ Fax ____________________