A D I REHAB

Patient is a: Male or Female Call Date:

Patient Name: _____
Last Name First Name Middle Initial

Address: _____
Street City, State Zip Code

Home # _____ Work # _____ Cell # _____

DOB: _____ SS#: _____ Marital Status: S M W D DP

Type of Injury: [ ] W/C [ ] Auto. [ ] Other Email Address: _____

Emergency Contact

Name: _____ **Relationship** _____

Phone#: _____

Physician's Info

Doctor's Name: _____ **Phone #:** _____

Date last seen: _____ **RX EXP:** _____

DIAGNOSES: _____ **CPT CODE:** _____

Have you seen a Chiropractor, Acupuncture or had Physical therapy for this injury somewhere else this year:[ ]Yes [ ] No # of visit:__

Primary Insurance

Insurance Name: _____ **Phone #:** _____

Group#: _____ **Subscriber ID:** _____ **Medicare Ltr.: A B Other** _____

Claim # _____ **DOI:** _____

Adjuster's Name: _____ **Phone #:** _____ **Ext:** _____

Name of Insured: _____ **Relationship:** _____

DOB: _____ **Subscriber SS#:** _____

Employer: _____ **Phone#** _____

Secondary Insurance

Insurance Name: _____ **Phone #:** _____

Group#: _____ **Plan #** _____ **Sub. Policy#:** _____

Name of Insured: _____ **Relationship:** _____

DOB: _____ **Subscriber SS#:** _____

Employer: _____ **Phone#** _____

Whom shall we thank for the referral to our office: _____

If you have Medicare insurance do you have a current Home Health case open: Yes _____ **No** _____

Booked: YES NO Appt. Date: _____ **Time:** _____ **WITH:** _____