



DATE \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_ Drivers License No. \_\_\_\_\_

Marital Status M \_\_\_\_\_ S \_\_\_\_\_ D \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Is this a work related injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of injury \_\_\_\_\_

Is this an auto accident related injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Is there an attorney involved? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been a patient at Lodi Physical Therapy? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_

*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 \_\_\_\_\_ Date of Birth \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Insurance ID Number \_\_\_\_\_ Subscriber Number \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employer/Work Number \_\_\_\_\_

**AUTO INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_  
Auto Insurance Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Policy Number \_\_\_\_\_ Claim Number \_\_\_\_\_  
Adjustor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**WORKERS' COMPENSATION INFORMATION**

Employer's Name (at time of injury) \_\_\_\_\_  
W/C Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Claim Number \_\_\_\_\_ Adjustor's Name \_\_\_\_\_

**ATTORNEY INFORMATION**

Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**AUTHORIZATION TO PAY LODI PHYSICAL THERAPY**

Assignment of Benefits

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

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_