Source Physical Therapy & Wellness

Patient Enrollment Information

PATIENT DEMOGRAPHICS (the shaded boxes are required to verify your insurance benefits)

Last Name _____ First Name _____ Initial _____

Address _____

Best Phone # _____ Birth Date _____ Soc Sec # _____

Work Phone _____ Employer _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

If your coverage is under another parties plan (i.e. Spouse/Parent), please provide the primary insured info here :

Primary Insured : ☐ Self ☐ Spouse ☐ Parent ☐ Other

Last Name _____ First Name _____ Initial _____

Soc Sec # _____ Birth Date _____

INSURANCE PLAN INFORMATION

Plan Type: ☐ Private Insur (i.e. BCBS, Aetna, Cigna, etc.) ☐ Medicare

☐ Worker's Compensation Case ☐ Auto/Legal Case

Insurance Company _____ *(i.e. BCBS, Aetna, Cigna)*

Member ID # _____

Group # _____

(800) Phone # _____

Secondary Insur *(if applicable)* _____

Insurance ID # _____ Group # _____

Internal Office Use Only : Your Physical Therapist Will Complete This Section Below

Billing Address _____

% Coverage _____ Deductible $ _____ Amount Met $ _____

Representative Name _____ Date/Time of Call _____

Auth Req'd ☐ Yes ☐ No Phone #: _____

Auth # _____ # Visits _____ Effective _____

Claim or Case # _____

Special Restrictions _____

Diagnosis (1) _____ ICD Code _____

(2) _____

(3) _____

Date of : Injury / Onset / Sx _____

Contact Physician _____ NPI # _____

Addr/Phone _____

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