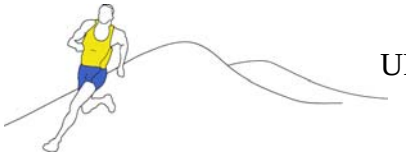

UPPER PERK PHYSICAL THERAPY AND SPORTS REHAB.,INC
NEW HOPE PHYSICAL THERAPY

Patient
Name:_____
First MI Last

Address: _____ Phone (home)_____
_____ Phone (cell)_____
Employer_____ Phone (work)_____
Address: _____ E-mail address: _____
Date of Birth:_____ Social Sec.#: _____
Emergency Contact:_____ Emergency Phone #: _____
Family Physician: _____ Family Physician Phone # _____
Referring Physician: _____ Referring Physician Phone # _____

INSURANCE INFORMATION:

Have you received physical therapy, occupational therapy or chiropractic services in the past year? Yes or No If yes, where? _____

1st Insurance: **Insurance Phone #: _____**
Subscriber:_____ Phone (home) _____
Address: _____ Phone (work) _____
_____ Date of Birth: _____

2nd Insurance: **Insurance Phone #: _____**
Subscriber:_____ Phone (home) _____
Address: _____ Phone (work) _____
_____ Date of Birth: _____

WORKMAN'S COMPENSATION/AUTOMOBILE CLAIM

Date/Onset of injury/accident: _____ Surgery: Yes or No Date_____
Accident Type/details: _____
Insurance Co. Name: _____ Claim #: _____
Insurance Address: _____
Adjuster's Name: _____ Adjuster's phone #:_____

EXPLANATION OF BENEFITS:

Policy Effective Date: _____ Deductible: $ _____ Single or Family:$ _____
Has deductible been met? $_____ How much remaining:$ _____
Max. paid by patient: $_____ % paid by Ins. Co. ___% Co-pay per visit: $_____
Max. visits allowed: _____ Visits already used: _____
Calendar year for visits: _____
Pre-Cert Required: YES OR NO PCP Referral YES OR NO
COMMENTS:
_____
_____
_____

This information will be used for billing purposes. Please present your insurance card and a form of Photo ID to the front desk receptionist. I have reviewed the above information and verify that it is correct.

Patient/Guardian Signature: _____ Date: _____
Verified by: _____ Date: _____