THE THERAPY CENTER
EXCEPTIONAL CARE. ESPECIALLY FOR YOU.

# Patient Demographics

Today's Date: _____

_____ Sex: M F
Patient Name

_____ _____ _____
Date of Birth Age Social Security Number

_____
Home Address (Please list billing address if different)

_____ _____ _____
City State Zip Code

**First Appointment:**

_____
Appointment Date

_____
Time Date

_____
Therapist

_____ _____ _____
Contact #1 Contact #2 Emergency Contact

May we release medical information to your emergency contact? Y N

_____ I would like to receive program updates from The Therapy Center Y N
Email Address

_____ _____ _____
Primary Physician Referring Physician Diagnosis

_____ Have you had home health services? Y N Date of home health discharge? _____
Date of injury/surgery Is your injury a result of an auto or work accident? Y N Do you have an attorney? Y N

Auto/Workers Comp: _____
Claim # Adjuster/Case Manager Phone #

## Primary Insurance

_____ _____
Insurance company Phone #

_____ _____
Member ID Group ID

_____ _____
Policy Holder DOB/SS#

## Secondary Insurance

_____ _____
Insurance company Phone #

_____ _____
Member ID Group ID

_____ _____
Policy Holder DOB/SS#

## Primary Insurance Benefits

_____
Date Verified Spoke To Reference Number

Copay:_____
CoIns:_____
DED:_____
DED Met:_____
OOPM:_____
OOPM Met:_____

Effective date:_____
Referral: Y N Pre- Auth: Y N
For Pre-Auth Call: _____
Policy Limits: _____
Other Instructions: _____
_____
_____

## Secondary Insurance Benefits

_____
Date Verified Spoke To Reference Number

Copay:_____
CoIns:_____
DED:_____
DED Met:_____
OOPM:_____
OOPM Met:_____

Effective date:_____
Referral: Y N Pre- Auth: Y N
For Pre-Auth Call: _____
Policy Limits: _____
Other Instructions: _____
_____
_____