

Summit Physical Therapy

16463 SW Boones Ferry Rd - Lake Oswego 97035

503-699-2955

Building #1

Patient Name:

Date:

Address:

Home Phone:

Work Phone:

Married:

Sex:

Age:

Date of Birth:

SS#

Employer:

Occupation:

Employer's Address:

Person to Contact in Emergency:

Phone #

Referring Physician:

PRIMARY. INSURANCE

Name of Company:

Grp#

ID#

Insurance address:

Does Insurance belong to:

SECONDARY INSURANCE (Medicare patients only)

Name of Company:

Grp#

ID#

Insurance address:

Phone#

Does Insurance belong to:

Date of accident/injury:

Work related?

Claim number for work related accident/injury:

AUTO ACCIDENT?

If yes, Name of Insurance Co.:

Adjuster Name:

Insurance address:

Phone#

Claim#

Attorney Handling Case?

Name:

Phone#

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize this office to release information necessary to secure the payment of benefits.

Signature: _____

Date:

FORMPG1