1. PATIENT INFORMATION		
First Name:	Last Name:	SSN:
Sex: F____ M____	DOB: MM_____/DD_____/YYYY_____	
Marital Status (please circle one of the following): S M D W		
Address:	Apt. #:	City:
State:	Zip Code:	Home Phone:
Work Phone:	Ext.:	Cell Phone:
Email Address:		
Primary Care Physician:	Referring Physician:	
Diagnosis:	Date of Onset/Injury:	
2. EMPLOYMENT INFORMATION		
Employer's Name:		Phone:
Address:		
Occupation:		
3. INSURANCE INFORMATION (if not applicable, please go to # 4 and check the appropriate payment form)		
Primary Insurance Company	Policy Holder's Name	Policy Holder's DOB
Policy Holder's Employer (if different from patient's employer): Policy Holder's SSN: Relationship to Policy Holder: ___Self ___Spouse ___Child Other(specify):_____		
Insurance ID #:	Group #:	
Primary Policy Holder's Address:	Home Phone: Cell Phone: Work Phone:	
Secondary Insurance Company	Policy Holder's Name	Policy Holder's DOB
Policy Holder's Employer (if different from patient's employer): Policy Holder's SSN: Relationship to Policy Holder: ___Self ___Spouse ___Child Other(specify):_____		
Insurance ID #:	Group #:	
Secondary Policy Holder's Address:	Home Phone: Cell Phone: Work Phone:	

If this is an auto insurance claim or worker's compensation, please fill out the following information: Auto:____ WC:____ Date of Accident: ____/____/_____ Insurance Name:_____ Claim #:_____ Adjuster Name and Contact Information:_____ _____
4. SELF-PAY: ___CHECK ___CREDIT CARD ___DEBIT CARD ___CASH
5. PATIENT REPRESENTATIVE

Emergency Contact Name:	Phone(s):
Patient's Representative or Legal Guardian Authorized to Access Protected Health Information: Name and Contact Information:	

I certify that the information provided above is true and correct. I hereby authorize ABIY PHYSICAL THERAPY & REHAB LLC to verify insurance coverage and benefits with my Insurance Provider. I understand that any co-payment or deductible is due at the time of service and that I am fully responsible for any amount not covered by my insurance. If ABIY PHYSICAL THERAPY & REHAB LLC does not participate with my insurance company or I am a self-paying patient, I understand that payment is due in full at the time of service.

_____ _____

Signature of Patient or Legal Guardian Date