

**ORTHOPEDIC & TMJ PHYSICAL THERAPY CENTER, 9204 SE Mitchell St., Portland, OR 97266**

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Patient's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

If minor, parent's name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #'s: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ Social Security # \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Marital status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Significant other's name \_\_\_\_\_

Referring Doctor full Name: \_\_\_\_\_ Phone # \_\_\_\_\_ FAX: \_\_\_\_\_

Other doctors and phone numbers involved in current care: \_\_\_\_\_

Are you seeing a chiropractor? If yes, please tell your therapist - *Insurance seldom covers DC & PT treatment on the same day, so we will need to schedule your appointments accordingly.*

Area(s) to be treated: \_\_\_\_\_ Allergies or chemical sensitivities: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**MOTOR VEHICLE ACCIDENT/PIP COVERAGE:**

Date of Injury: \_\_\_\_\_ State MVA occurred: \_\_\_\_\_ Were you driving on-the-job? Y N

Were you the driver? Y N Were you the passenger? Y N Have you had an IME Y N If so, date: \_\_\_\_\_

Insured's name: \_\_\_\_\_ Phone# \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insured's address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_ Adjuster: \_\_\_\_\_

Auto Ins. Company (not agent): \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who is your **Health Insurance** carrier? \_\_\_\_\_ Phone# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's name: \_\_\_\_\_ ID # \_\_\_\_\_ Group: \_\_\_\_\_

Do you have an **Attorney**? No \_\_\_ Yes \_\_\_ If yes: Attorney's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ Other MVA claims? N Y If so, when \_\_\_\_\_ info re case: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I found you initially by: Doctor Referral (Name): \_\_\_\_\_ Friend (Name) \_\_\_\_\_

Yellow Page Ad \_\_\_ Internet (Site) \_\_\_\_\_ Other \_\_\_\_\_

If I am unable to keep my appointment, I will give at least 24 hours notice. Otherwise, I understand I may be charged for the appointment time reserved for me. Insurance will not pay for broken appointment charges

**I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment on the billing form. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the billing form.**

Patient or Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_