ATLAS PHYSICAL THERAPY & SPORTS MEDICINE

Date:_____

PATIENT INFORMATION

Patient Name _____ Account #_____
LAST FIRST MI

Address _____
STREET CITY STATE ZIP

Home (_____)_____ E-mail Address _____

DOB _____ Age _____ Marital Status _____ SSN _____ Male ____ Female_____

Employer _____ Work (_____)_____

Address _____ License #_____
STREET CITY STATE ZIP

Emergency Contact _____ Phone (_____)_____

Person Responsible for Charges_____ Relationship to Patient _____

Address _____
STREET CITY STATE ZIP

Employer _____ Work (_____)_____

Referring Physician _____Phone (_____)_____Fax (_____)_____

How did you hear about us?_____

If you were referred to us, by whom? _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder_____ Relationship to Patient _____
LAST FIRST MI

Address _____ Phone (_____)_____
STREET CITY STATE ZIP

DOB _____ SSN _____ Insurance Type: ___ Private ___WC ___Medicare ___Auto ___Lien ___Cash ___HMO

Insurance Company _____ Phone (_____)_____

Address_____
STREET CITY STATE ZIP

Policy or Claim # ___ Group # _____ Plan _____

Does the Patient have additional coverage**?** Yes ____ No_____ Policy Holder_____

EXPLANATION OF BENEFITS (Office Use Only)

Policy Effective Date _____ Visit Limitation _____ Deductible $ _____ Amt Met $_____

Benefits Quoted By _____ Copay $_____ Benefits_____/_____% Out of Pocket_____ Met_____

Case Manager _____ Phone (_____)_____ Fax (_____)_____

Pre Cert/Auth # _____ # Visits Allowed _____ Exp. Date _____

Comments _____