

# Advance Physical Therapy & Sports Rehab

1626 N. Spring St. Suite B, Beaver Dam, WI 53916  
 Telephone: (920) 356-0122 Fax: (920) 356-0470

## PATIENT INFORMATION

LAST NAME		FIRST	MI	DATE OF BIRTH / /	AGE	SOCIAL SECURITY NUMBER	SEX M / F
HOME ADDRESS			CITY		STATE	ZIP CODE	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER		E-MAIL ADDRESS - Ok to contact? <input type="checkbox"/>		CELLPHONE - Ok to contact? <input type="checkbox"/>		HOME PHONE - Ok to contact? <input type="checkbox"/>	
EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYED <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> RETIRED <input type="checkbox"/> N/A			EMPLOYER NAME/SCHOOL NAME			TITLE/POSITION	
WORK ADDRESS			CITY	STATE	ZIP CODE	WORK PHONE - Ok to contact? <input type="checkbox"/>	

## EMERGENCY CONTACT, LEGAL GUARDIAN, INSURED INFORMATION

LAST NAME		FIRST	MI	HOME PHONE			
ADDRESS			CITY		STATE	ZIP CODE	
RELATIONSHIP	EMPLOYER			WORK PHONE			

## REFERRING PHYSICIAN INFORMATION

LAST NAME		FIRST	MI	UPIN#			
ADDRESS				TELEPHONE		FAX	

## TYPE OF CLAIM

WORKERS COMPENSATION    
  AUTO LIABILITY    
  HEALTH INSURANCE    
  PRIVATE PAY

## PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		EFFECTIVE DATE	IDENTIFICATION NUMBER		GROUP NUMBER		
ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE	
POLICYHOLDER (If other than patient)		SOCIAL SECURITY #		RELATIONSHIP TO PATIENT		DATE OF BIRTH	

## SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME		EFFECTIVE DATE	IDENTIFICATION NUMBER		GROUP NUMBER		
ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE	
POLICYHOLDER (If other than patient)		SOCIAL SECURITY #		RELATIONSHIP TO PATIENT		DATE OF BIRTH	

## WORKERS COMPENSATION AND AUTO ACCIDENT INFORMATION

WORKERS COMPENSATION/AUTO INSURANCE NAME		DATE OF INJURY	CLAIM #				
ADDRESS			CITY	STATE	ZIP CODE	TELEPHONE	
TYPE OF INJURY							
SUBSCRIBER NAME			ADDRESS			TELEPHONE	
ADJ/CASEWORKER				TELEPHONE			FAX
ATTORNEY NAME				TELEPHONE			FAX

**SIGNATURE OF PATIENT** \_\_\_\_\_ **DATE** \_\_\_\_\_