MYERS® Physical Therapy

Please fill out in Black ink

PATIENT INFORMATION PRIVATE/MEDICARE

Chart Number___________________________________

Location______________________________________

Diagnosis/Body Part :_____________________________

Patient Name :_________________________________

(First, Middle, Last)

Address :______________________________________

____

City :_______________State :___Zip Code :________

Drivers License :________________________________

Emergency Contact :_____________________________

Emergency Contact Phone Number :________________

Dx.________ Dx.________ Dx.________ Dx. ________

Billing Therapist______________________________

Date of Appt./Time :______________________

Date of Birth :__________________________

Date of Injury :_________/_________/_________

SS# :_________________________________

Primary Phone :_________________________

Work Phone :___________________________

Cell Phone :____________________________

Marital Status : S☐ M☐ W☐ D☐

Gender : M☐ F☐

Email :________________________________

INSURANCE INFORMATION

Primary Insurance Company/Type :_______________________

Subscriber ID# :____________________________________

Called Insurance : Date/Time/Name____

Deductible :____________ Deductible met :______________

Effective Date :__________ Approved visits/max :__________

Claims Address :____________________________________

____

City :________________ State :____ Zip Code :__________

Insured Name (if different from patient) __________________

Insured Phone :______________________________________

Insured Date of Birth :__________________________________

Relation to Patient :____________________________________

Plan Name :_______________________________

Group # :__________________________________

Out of Pocket :______________ Met :____________

Copay/co ins.______________________________

Rx necessary :______________________________

Ins. Phone # :______________________________

Ins. Fax # :________________________________

In Network ? _______________________________

Insured SS# :_______________________________

Insured Address :____________________________

City_________________ St____ Zip___________

Secondary Insurance :_________________________________

Subscriber ID# :_____________________________________

Effective Date :__________ Approved visits/max__________

Called Ins : Date/Time/Name____

Coverage :____

Insured Name (different from patient)__________________

Insured SS# :____

Relation to Patient :___________________________________

Insured Address : _____________________________________

City : _______________ State :____ Zip Code :___________

Plan Name :_______________________________

Group # :__________________________________

Ins. Phone # :______________________________

Ins. Fax # :________________________________

Rx Necessary: ______________________________

Insured Phone :_____________________________

Claims Address : ____________________________

____

City________________ St_____ Zip____________

Referring Physician : ______________________________

Address : ____

____

City :____________ State :____ Zip Code :___________

UPIN : _____________________________________

Phone # : ___________________________________

RX : Yes/No – RX Date :___________________________

Specialty_____________________________________