MYERS® Physical Therapy

Please fill out in Black ink

PATIENT INFORMATION WORKERS COMP

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 :____________________________

EMPLOYER'S INFORMATION

Employer's Name ____________________________________

Employer Phone # ____________________________

Employer's Address :____________________________________

____

City :________________ State :____ Zip Code :__________

INSURANCE INFORMATION

Name of Insurance Company :____

Claim # :____________________________________

Adjustor :____________________________________

Phone # :____________________________________

Authorized Number of Visits____________________________

Address : ____________________________________

____

City________________ St_____ Zip____________

Authorization Number :____________________________

Fax # :____________________________

Called adjustor date/time :________________________

REFERRING PHYSICIAN INFO

Referring Physician : ____________________________________

Address : ____________________________________

____

City :_____________ State :_____ Zip Code :___________

UPIN : ____________________________________

Phone # : ____________________________________

RX : Yes/No – RX Date :________________________

Specialty____________________________________