WELLSMART REHAB & FITNESS

Michael P Holliday, PT, ATC, CSC

PATIENT INFORMATION

Patient Name: _____
First Middle Last

DOB:_____ Marital Status: M S D W Sex: M / F

Home Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ Work: _____

Occupation: _____ Employer:_____

Employer Address:_____
Street City State Zip

Social Security #: _____ Driver's License #: _____

Email Address: _____

Spouse Name: _____

Home Phone: _____ Cell: _____ Work: _____

RESPONSIBLE PARTY: (PARENT OR GUARDIAN)

Name: _____ Relation: _____ Phone: _____

Referred By:_____ Email Address: _____

INSURANCE INFORMATION: (copies of your card(s) are required)

Primary: _____ ID #:_____ Group #: _____

Subscriber Name: _____ Subscriber DOB:_____

Secondary: _____ ID _____ Group #: _____

Subscriber Name: _____ Subscriber DOB:_____

Worker's Comp Claim #: _____ Injury Date: _____

Attorney's Name: _____ Phone: _____

ASSIGNMENT AND RELEASE:

This claim will be filed with your insurance company. Should the insurance deny payment, the patient or responsible party will be responsible for full payment for services provided.

I hereby authorize this office to release all information necessary to secure payment of benefits. A photocopy of this authorization is approved for billing purposes.

_____ _____
Signature of Responsible Party Date