First Contact & Payment Verification

Date of Contact	Staff Name	Appt. Time	Appt. Date

Condition

Area of pain/problem			Date pain/problem began
Mechanism of Injury	† Work † Auto † Other		Date of similar pain/problem in past
Impairments? † Sleep † Bathroom † Sit † Walk † Other:		† Worsening † Better † Same	† Hospitalized † Missing work Since when?

Patient Info

Patient Name (Last, First)		Age	DOB	† Male † Female
Hm Phone	Other Phone	Email		
Street Address		City		State & Zip
How did you hear about us?		Social Security #		

Payment Information

PRI WC LIEN MC AUTO SELF-PAY (discount/CC info to reserve) PAY PLAN other:				
Insurance Company Name			Referring Physician	
Street Address			City	State/Zip
Subscriber Name (if other than self)	† Parent † Spouse † Other	DOB	ID #	Group #
(WC only) Claim Number	Adjuster Name		Phone #	Date of injury
Employer Name		Occupation	Employer Phone	
Emergency Contact Name		Relationship	Emergency Contact Phone	
Date of Verification	Staff Name	Comments:		

PRI	Date of Eligibility	Copay $	Deductible $	Met $	Coinsurance %	Maximums?	Notes:
WC	Date of Auth.	# Visits	Exp. Date	Auth #		Person Auth	
Lien	Date Agreement sent	Attorney Name		Address			Date of Accident
Auto	Third Party Name			Insurance Name		Phone #	Claim #
Self	† Visa † MC † Amer Ex	Name on Card		Card #		Exp Date	3 digit code (on back)
	Date of Verification	Staff Name		Comments:			