



## WELCOME TO FISCHER SPORTS PHYSICAL THERAPY & CONDITIONING, L.L.C.

It is our policy to bill qualifying insurance companies directly for services rendered. It is possible your insurance will not cover our entire fee. Although we will be glad to complete required insurance forms, it remains the responsibility of each patient to insure payment of their bill. Our office will be most happy to discuss with you any questions you may have regarding the fees for therapy. To enable our office to be of maximum assistance relative to insurance benefits, please provide the following information:

(PLEASE PRINT)

### PATIENT INFORMATION

Patient's  
Last Name \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

H Phone (\_\_\_\_) \_\_\_\_\_

W Phone (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_

Sex M F Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Referring Physician: \_\_\_\_\_

Marital Status: Single  Married  Other

Student Yes  No

### RESPONSIBLE PARTY AND/OR DEPENDENT INFORMATION

Last Name \_\_\_\_\_ First \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Hm Phone (\_\_\_\_) \_\_\_\_\_

Wk Phone (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_

Policy # \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_

DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex M F

### EMPLOYER INFORMATION

Name of Employer \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Contact Person \_\_\_\_\_

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

### AUTO RELATED INJURY

(COMPLETE ONLY IF INJURY OCCURRED IN TRAFFIC)

Were you involved in a traffic accident? Yes  No

Date of Accident: Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Name of Automobile Insurance Carrier  
\_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Policy/Claim Number \_\_\_\_\_

Phone Number of Auto Insurance Co.: \_\_\_\_\_

### WORK RELATED INJURY

Were you injured at work? Yes  No

Date of Injury: Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Name of Compensation Carrier: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Claim Number: \_\_\_\_\_

### MEDICAL HISTORY

PLEASE TAKE A MOMENT TO COMPLETE THE QUESTIONS BELOW. DEPENDING ON YOUR ANSWERS, WE MAY MODIFY OUR TREATMENT PROCEDURES FOR THEIR EFFECTIVENESS AND YOUR SAFETY. THANK YOU!

Do you have or have you had any of the following:

Cancer Yes  No

Diabetes Yes  No

Epilepsy Yes  No

Heart Disease Yes  No

High Blood Pressure Yes  No

Metal Implants Yes  No

Respiratory Problems Yes  No

Are you pregnant? Yes  No

Psychological Problems Yes  No

Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Are there any other current medical problems we should be aware of? \_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION**

FOR MAXIMUM ASSISTANCE IN BILLING, PLEASE COMPLETE EACH QUESTION OF THIS SECTION. THE RECEPTIONIST WILL ASK YOU FOR A COPY OF YOUR INSURANCE CARDS TO KEEP ON FILE IN YOUR CHART. THIS WILL SPEED UP THE BILLING PROCESS WHEN THE INSURANCE COMPANY REQUESTS VERIFICATION. THANK YOU FOR YOUR ASSISTANCE.

**PRIMARY INSURANCE CARRIER**

CODE (Office Use Only): \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Insurance Contact Person (if known): \_\_\_\_\_  
IF INSURED IS NOT PATIENT: \_\_\_\_\_  
Insured's Employment: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_

**SECONDARY INSURANCE CARRIER**

CODE (Office Use Only): \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Insurance Contact Person (if known): \_\_\_\_\_  
IF INSURED IS NOT PATIENT: \_\_\_\_\_  
Insured's Employment: \_\_\_\_\_  
Insured's Date of Birth: \_\_\_\_\_

OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY - OFFICE USE ONLY

Intake completed by: \_\_\_\_\_  
Authorization #: \_\_\_\_\_  
Adjustor: \_\_\_\_\_