



To help keep health care premiums down insurance companies research claims, to see if another carrier or party may be responsible. Therefore we do everything we can to assist in this process. Filling out this form will help us help you to ensure your claim is paid by cutting down on the amount of denied claims from insurance companies.

Patient Insurance Information

Patient Name _____

Please circle your insurance:

Private Insurance Self Pay Workers Comp Motor Vehicle Third Party Liability

If you have secondary insurance please provide that information at the time of service.

What is the medical condition you are being seen for? i.e. neck, back, left foot, right shoulder, etc.

Injury Information

Date of accident / injury / condition or illness: _____

Accident / injury/ condition or illness occurred at:

A business Your employer Residence Auto related
 Sports or recreational activity Other

How did the injury / accident / illness occur? Was it your fault? no yes

Where did the injury / accident / illness occur? Is this your home? no yes

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____

Please complete the following section(s) based on your insurance type. You only need to complete the section(s) that pertain to your insurance. If you have private insurance you may skip to the end of the form.

FILL OUT COMPLETELY

Self Pay

As a self pay patient I understand I am responsible for all charges at the time of service.
Patient Initials _____

Workers Comp

W/C Referring Dr _____ Primary Care Physician _____
W/C Carrier _____ Claim number _____
Address _____
City _____ State _____ Zip _____
Adjustor _____
Phone # _____ Fax # _____
Additional contacts (*nurse/lawyer if any*)

Employer at time of accident: _____
Name _____
Address _____
City _____ State _____ Zip _____
Supervisor _____ Phone _____

Motor Vehicle/Third Party

MVA Carrier _____ Claim number _____
Address _____
City _____ State _____ Zip _____
Adjustor _____
Phone # _____ Fax # _____
Additional contacts (*nurse/lawyer/additional MVA insurance if any*)

What state did the accident occur?

Please provide us with a copy of all insurance. If this is due to a motor vehicle accident provide a copy of the at fault drivers insurance, your motor vehicle insurance, the accident report and your private insurance. For third party injury's a copy of your private insurance is also needed.
Yes No I have contacted my private insurance concerning this accident.
Initials _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverage. All services must be paid for at time of service unless we are billing private insurance. **It is the patient's responsibility to provide us with insurance for billing purposes.**

Your home number _____ Cell Phone _____
Daytime phone _____ Spouse _____
Signature _____ Date _____