INSURANCE INFORMATION

Date:_____

Client's First Name:_____ M.I.: _____Last Name: _____

Address: _____

Social Security#: _____ Marital Status: _____

Name of Employer: _____

D.O.B.:_____

Insurance Company: _____

Ins. Co. Address: _____City: _____

State: _____ Zip:_____Phone: _____

Insurance Contact Person: _____

Insurance Claim Number: _____

Policy Number: _____Group or I.D.#: _____

Subscriber's First Name:_____ M.I.: _____Last Name: _____

Subscriber's S.S.#:_____D.O.B.: _____

Name of Employer: _____

Referring Dr. _____I.D.# or Ref. Dr. _____

Ref Dr. Address: _____

Is this your Primary Care Provider? _____ If No, please provide name: _____

Ref. Dr. Phone #: _____Date of Injury:_____

Diagnosis by Dr.: _____ICD-9 Code: _____

PRIVATE HEALTH INSURANCE

Actively Enrolled ❑ yes ❑ no

Waiting Period ❑ yes ❑ no

Benefit Limit _____

Massage Benefits Grouped with_____

Deductible _____ has been met? ❑ yes ❑ no

Copay Amount_____ or % Insurance Pays _____

Contracted Fee (if applicable) _____