

EverFit Physical Therapy and Fitness

Patient's Name: _____

I am a self pay patient: YES NO

I have a co-pay for office visits <input type="checkbox"/> YES <input type="checkbox"/> NO	Amount of co-pay per visit \$
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Primary Insurance Information:	Secondary Insurance Information
Insurance Company Name	Insurance Company Name
Billing Address	Billing Address
City	City
State	State
Phone	Phone
Policy Holder Name Relationship to Patient Self Spouse Child Other	Policy Holder Name Relationship to Patient Self Spouse Child Other
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder Social Security #	Policy Holder Social Security #
Policy ID	Policy ID
Group Number	Group Number

Workers Compensation Claim? <input type="checkbox"/> YES <input type="checkbox"/> NO	Auto Accident Claim? <input type="checkbox"/> YES <input type="checkbox"/> NO
Insurance Company Name	Insurance Company Name
Billing Address:	Billing Address:
City	City
State	State
Phone	Phone
Fax	Fax
Case Manager's Name	Adjuster's Name
Case Manager's Phone	Adjuster's Phone
	Claim Number:

Employment Information for Workers Compensation	
Employers Name	Contact Person

Street Address	
City	State
Phone	Fax