SYNERGY REHAB

Physical Therapy Through Healing Hands

Date:_____ RX :___Yes ___No How were you referred to us? _____ DX:_____

Patient Name: Last _____ First _____

Address:_____ City:_____State ____Zip:_____

Home Ph: _____ Cell Ph: _____

SSN #: _____DOB: _____*Email:*_____

Attending/Ref. Physician:_____Phone:_____

Address: _____ Fax:_____

Emergency Contact:_____Relationship:_____Phone:_____

Employer:_____Occupation:_____

Address:_____Work Phone: _____

Insurance # 1_____

ID/Claim#:_____

Phone:_____

Subscriber_____DOB:_____

Group#:_____ Auto____Wcomp____

Adjuster/Case Worker_____

DOI:_____ Phone: _____

Insurance # 2_____

ID/Claim#:_____

Phone:_____

Subscriber_____DOB:_____

Group#:_____ Auto_____Wcomp_____

Adjuster/Case Worker_____

DOI:_____ Phone: _____

I have been informed of my insurance benefits as told to Synergy Rehab by my insurance company. I understand that this is not a guarantee of payment from my insurance company.

Date of 1st Visit: _____ DAYS: M T W Th F S TIME: _____

Patient Signature: _____ Date: _____