

RUDI E. IDE & ASSOCIATES

PATIENT DEMOGRAPHICS

DATE: _____

LAST NAME: _____ FIRST NAME: _____

I PREFER TO BE CALLED _____

DATE OF BIRTH: _____ SSN#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS _____ CELL PHONE: (____) _____

HOME PHONE (____) _____ WORK # (____) _____

REFERRING DOCTOR: _____

IS THIS CONDITION THE RESULT OF ANY KIND OF AN ACCIDENT?

_____ YES _____ NO

WHAT INSURANCE COMPANY SHOULD BE BILLED FOR THESE PHYSICAL THERAPY VISITS (Circle One)

- Medicare and Secondary Insurance _____
- Secondary Insurance Company _____
- Commercial Insurance _____
- Motor Vehicle _____
- Self Pay _____
- Other _____

As a courtesy we will submit all claims to your primary and secondary insurance companies and we follow all current guidelines. There is no absolute guarantee of payment in full from your insurance company and you will be responsible for any deductibles not met.

PATIENT SIGNATURE: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP _____