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 _____