OPTIMUM CARE THERAPY
PHYSICAL THERAPY, CHIROPRACTIC SERVICES & SPORTS MEDICINE

PATIENT INFORMATION FORM **OFFICE USE ONLY**: □WC □PI □MEDICARE □OTHER______________________

TODAY'S DATE:

PATIENT NAME (Last, First, Initial):	DATE OF BIRTH:	AGE:	SEX: □MALE □FEMALE
ADDRESS:	CELL PHONE:	E-MAIL:	
SPOUSE'S NAME (IF MARRIED):	IF CHILD, PARENTS OR GUARDIAN NAME:	PHONE#:	

PHYSICIAN'S NAME (Last, First, Initial):	SPECIALTY:
ADDRESS:	PHONE:
TYPE OF INJURY: □WORK INJURY □AUTO ACCIDENT □SPORTS INJURY □OTHER (SPECIFY): DATE OF INJURY/ ONSET:	
DIAGNOSIS:	AREA(S) OF BODY INVOLVED:

INSURANCE INFORMATION: PLEASE PROVIDE US WITH YOUR INSURANCE INFORMATION. FOR WORK RELATED INJURIES, PLEASE PROVIDE YOUR EMPLOYER'S WOKER'S COMPENSATION INSURANCE CARRIER INFORMATION. IF THE ACCIDENT WAS NOT AN AUTO ACCIDENT THAT WAS WORK RELATED, PLEASE PROVIDE YOUR AUTO INSURANCE INFORMATION. FOR OTHER TYPES OF ACCIDENTS, PLEASE PROVIDE YOUR PERSONAL HEALTH INSURANCE INFORMATION.

INSURANCE TYPE: □WORK COMP □AUTO □MEDICARE □PRIVATE □OTHER (SPECIFY): POLICY/GROUP #:	INSURED NAME:	
PRIMARY INSURANCE CO. ADDRESS:	PHONE:	ADJUSTOR NAME (IF APPLICABLE):
WORK COMP. CLAIM #(IF APPLICABLE):	INSURED SSS#:	
SECONDARY INSURANCE: POLICY/GROUP #:	INSURED NAME:	
INSURANCE CO. ADDRESS:	PHONE:	

ATTORNEY'S NAME (Last, First, Initial):	LAW FIRM:
ADDRESS:	PHONE:
EMPLOYER'S NAME:	POSITION/JOB TITLE:
ADDRESS:	PHONE:

NAME AND PHONE NUMBER OF NEAREST RELATIVE NOT LIVING WITH YOU:	**OFFICE USE ONLY**: INSURANCE AUTHORIZATION INFO:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO OPTIMUM CARE THERAPY FOR SERVICES FURNISHED. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIM ON MY BEHALF. I PERMIT A COPY OF THIS AUTHORIZATION TO BE AS VALID AS THE ORIGINAL WHERE APPLICABLE. I AUTHORIZE FILING A LIEN AGAINST ANY AND ALL THIRD PARTY LIABILITY ACTION RELATING TO THE NEED FOR TREATMENT, INCLUDING WORKERS COMPENSATION CASES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND ALL THE ABOVE TERMS.

PATIENT'S SIGNATURE:____ DATE:___________________________