DRUMHILL PHYSICAL AND SPORTS THERAPY
10 Jean Ave. Suite 10, Chelmsford, MA 01824

Name____Date Of Birth___________Age_____

Address____ S.S. #_____________________________
(Number and Street)

____Occupation___________________
(City and State) (ZIP)

Telephone_________________Cell______________Work_____________Email________________________

Employer____

Work Address____

****Have you been treated by another Physical Therapy office in the last 12 months? _____________**

Insurance Company:____ID #_____________________

Subscriber______________________Relationship to Sub_______________Subscriber DOB________________

***** If MEDICARE : Have you had <u>any</u> Home Care (VNA) services within the past year? ____________**

CHECK IF WORK. COMP. OR AUTO ACCIDENT W/C CLAIM?_____AUTO?_____DATE OF INJURY?_______________

Secondary Insurance Company:________________________________ID_______________________

Subscriber______________________Relationship to Sub_______________Subscriber DOB________________

Primary Doctor_________________________________Referring Doctor___________________________

In case of emergency, whom should we contact?_____________________________________

Relationship___________________________Telephone Number___________________________

IMPORTANT: Copays vary with insurance plans. All Blue Cross and Blue Shield plans have either a copay or a co-ins amount for each therapy visit. Some insurance plans require pre-authorization. Please check with your insurance company if you are unsure about copays, co-ins, deductibles, or referrals. Should your insurance company deny payments, you will be responsible for payment of charges.

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY IF NECESSARY TO PROCESS MY CLAIM.

SIGNATURE_______________________________________DATE_________________________________