B & B Physical Therapy INC.

24355 Lyons Ave. Suite 100

Newhall, CA 91321

Date____________ Referring Doctor______________________________

Patient Last Name____________________ First___________________ M.I.____

Home address____ Apt#________

City_______________________ State______________ Zip Code_____________

Home Number___________________ Cell Number________________________

SS#__________________________ Driver License #_______________________

Marital Status _____________ Spouse Name ______________________________

Date of Birth _______________ Sex M___F___

Is this a work related injury? Yes_____ No_____ Date of Injury___________
Is this injury an auto accident? Yes____ No_____ Is there an attorney involved? Yes___ No___

Patient Work Information

Employer's Name____

Employer's Address____

City___________________________ State_______ Zip Code_____________

Work Phone Number ___________________ Extension __________________

Occupation____

Private Insurance Information

(Please provide a copy of your insurance card)

Is this your coverage? Yes___ No___ If no, who is the primary? _________________

You relationship to the insured_________________ Policy Number_______________

Group Number __________________ Certificate Number_______________________

Insurance Company Name ____

Medicare Number

Medicare Number (if applicable)____

Secondary Insurance Information

Name of Insured______________________________ Relation to you_______________

Insurance Policy Number _______________________Group Number_______________

Insurance Company Name_______________________Phone #_____________________

Auto Insurance Information

Please only fill out if this is an auto accident injury

Name of Insured ____

Auto Insurance Company Name____

Address ____

City ________________________State _________________ Zip Code _______________

Policy Number ________________________ Claim Number ______________________

Adjustor's Name _______________________ Phone Number ______________________

Worker's Compensation Information

Please only fill out if this is a work related injury

Employer's Name (at time of injury) ____

Worker Comp. Insurance Carrier Name ______________________________________

Address ____

City ___________________________ State _________________ Zip Code __________

Claim Number _______________________ Adjustor's Name _____________________

Attorney Information

Name _____________________________________ Phone Number _________________

Address ____

City _________________________ State __________________ Zip Code ___________

Authorization To Pay B & B Physical Therapy INC.

Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to B & B Physical Therapy INC. and I understand that I am financially responsible for non-covered services. I also authorize B & B Physical Therapy INC. to release information to process this claim.

Signed ____ Date _____________________