B & B Physical Therapy INC.

24355 Lyon 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____

Medicare Number

Medicare Number (if applicable) ____

Private Insurance Information

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 ____

Address ____________________________ City____________________________

State _____ Zip ______________________ Phone Number ___________________

Secondary Insurance Information

Name of Insured_____________________________ Relation to you_______________

Insurance Policy Number ______________________Group Number_______________

Insurance Company Name______________________ Phone #____________________

Insurance Company Address____

City _____________________ State _____________________ Zip Code___________

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 to release information to process this claim.

Signed ______________________________________ Date ___________________