INITIAL PATIENT QUESTIONNAIRE

Patient's Name____ SS#___________________________

Insured Name____ SS#___________________________

Insurance Company____________________________________ Date of Injury_________________________

Insurance Phone #______________________________________Group/Policy #_________________________

Claim or Case #____

Referring Physician Name____

Address____

Physician's Phone #____

Diagnoses Number(s)____

____

Office Use Only

Insurance Company____

Attn: (Insurance Adjustor, Team #, etc)____

Mailing Address____

Phone #_____________________________________ Fax #____

Are benefits exhausted? Yes❐ No❐

Has deductible been met? Yes❐ No❐

What percentage does insurance cover?_______%