# *Haile Physical Therapy, LLC*

410-571-1151

## **Patient Information Sheet** ( PLEASE PRINT)

NAME_____ DATE_____

ADDRESS_____CITY AND ZIP_____

DATE OF BIRTH_____AGE_____

HOME PHONE (_____)_____ ___MOBILE PHONE_(_____)_____

WORK PHONE(_____)_____EMAIL_____

EMPLOYER_____

WORK ADDRESS_____

REFERRING PHYSICIAN'S NAME AND ADDRESS_____

_____

*IN CASE OF EMERGENCY PLEASE CALL*_____

PHONE # (_____)_____RELATION_____

**INSURANCE INFORMATION**

***PATIENT IS RESPONSIBLE FOR VERIFICATION OF PT BENENFITS***

PRIMARY INSURANCE CO._____GRP#_____ POLICY #_____

SUBSCRIBER/POLICY HOLDER'S NAME_____RELATION TO PATIENT_____

DATE OF BIRTH_____EMPLOYER NAME & ADDRESS_____

_____

SECONDARY INSRUANCE CO._____GRP #_____POLICY #_____

SUBSCRIBER/POLICY HOLDER'S NAME_____RELATION TO PATIENT_____

DATE OF BIRTH_____EMPLOYER NAME & ADDRESS_____

_____

**PIP ( IF APPLICABLE)**

NAME OF INSURANCE CO. _____CLAIM #_____

ADJUSTER'S NAME_____ PHONE # (_____)_____

**WORKMAN'S COMENSATION ( IF APPLICABLE)**

EMPLOYER'S NAME _____INSURNACE CO. NAME_____

ADDRESS ( CITY, STATE AND ZIP)_____

CLAIM#_____DATE OF ACCIDENT_____

**I authorize the release of any medical information necessary to process this claim.**
**I authorize and request payment be made to Haile Physical Therapy, LLC.**
**I understand I am financially responsible for charges not covered by my insurance company.**

Signature Date