PHYSICAL THERAPY CENTER OF TUSTIN INC.

Patient Information

Name_____Date_____
Sex _____ Marital Status _____ Age _____ Date of Birth _____
Home Address_____ City _____ Zip _____
Home Phone_____ Patient SS# _____
Patient Employed By _____ Address _____
City _____ Zip _____ Phone _____
Spouse/Parent/Guardian Name_____ Date of Birth _____
Employed By _____ Address _____
City_____ Zip _____ Phone _____

INSURANCE INFORMATION

Is This A Work Related Injury? ____ Yes _____ No Date of Injury_____
Insured Full Name _____ Date of Birth _____ SS# _____
Name of Insurance Company_____ Policy/Group# _____
Mailing Address_____
Telephone_____ Employer _____

Do You Have a Secondary Insurance? ____Yes _____ No
Insured's Full Name_____ SS# _____
Name of Insurance Company_____ Policy/Group# _____
Mailing Address_____
Telephone_____ Employer _____

Referred To This Office By _____

In Case Of Emergency Notify _____ Telephone _____

AUTHORIZATION TO PAY

I hereby authorize the _____Insurance Company to pay by check made out and mailed directly to:
Physical Therapy Center Of Tustin Inc.

The medical and surgical expense benefits allowable and otherwise payable to me under my current Insurance policy as payment toward the total charges for PORESSIONAL SERVICES RENDERED. This payment will not exceed my Indebtedness to above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said PROFESSIONAL SERVICE. I also hereby authorize Physical Therapy Center of Tustin Inc. to furnish the Insurance company or others not authorized by law, will full information regarding treatment rendered, when requested.

_____ _____
Patient's Signature Insured's Signature

18102 Irvine Blvd., Suite 207 Tustin, CA 92780
Phone: (714) 505-2966 Fax: (714) 505-2976