

# 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 PROFESSIONAL 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