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