

LAST NAME \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
STREET \_\_\_\_\_  
CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
E-MAIL \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_ CELL ( ) \_\_\_\_\_  
WORK PHONE ( ) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SEX M F SOC SEC NUMBER \_\_\_\_\_  
DRIVERS LICENSE STATE \_\_\_\_\_ NUMBER \_\_\_\_\_ EXP \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE NUMBER ( ) \_\_\_\_\_

MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED  
SPOUSE'S FULL NAME \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

DATE OF ILLNESS, SURGERY OR INJURY \_\_\_\_\_

IS THIS RELATED TO AN AUTO OR WORK ACCIDENT? \_\_\_\_\_ AUTO WORK  
CLAIM NUMBER \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_  
ADJUSTOR'S NAME \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ EXT \_\_\_\_\_  
INSURANCE CO NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

#### PRIVATE HEALTH INSURANCE OR MEDICARE

INSURANCE CO NAME \_\_\_\_\_  
ADDRESS TO SUBMIT CLAIMS \_\_\_\_\_  
CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE NUMBER ( ) \_\_\_\_\_  
WHO IS THE POLICY HOLDER? \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
ANNUAL DEDUCTIBLE \_\_\_\_\_ AMOUNT MET TO DATE \_\_\_\_\_  
CO-PAYMENT AMOUNT PER VISIT \_\_\_\_\_

#### SECONDARY INSURANCE

INSURANCE CO NAME \_\_\_\_\_  
ADDRESS TO SUBMIT CLAIMS \_\_\_\_\_  
CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE NUMBER ( ) \_\_\_\_\_  
WHO IS THE POLICY HOLDER? \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**ATTORNEY INFORMATION**

**NAME** \_\_\_\_\_ **PHONE (    )** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_  
**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**AUTO MED-PAY INSURANCE**

**NAME OF INSURED** \_\_\_\_\_  
**AUTO INSURANCE COMPANY NAME** \_\_\_\_\_  
**ADDRESS** \_\_\_\_\_  
**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_  
**POLICY NUMBER** \_\_\_\_\_  
**CLAIM NUMBER** \_\_\_\_\_ **DATE OF INCIDENT** \_\_\_\_\_  
**ADJUSTOR'S NAME** \_\_\_\_\_ **PHONE (    )** \_\_\_\_\_

**AUTHORIZATION TO PAY INNIS NEILSON PHYSICAL THERAPY dba BONITA PHYSICAL THERAPY  
ASSIGNMENT OF BENEFITS**

I understand that I am financially responsible for payment for all professional services provided to me by Bonita Physical Therapy. I understand that Bonita Physical Therapy submits claims to insurance companies on my behalf as a courtesy to the patient and that all treatment provided to me is at my request and is my financial responsibility. I understand that I am responsible for understanding my insurance plan's benefits and limitations. I understand that I am financially responsible for any amount applied to the deductible on my policy, co-payments, and/or services not covered by my insurance plan. I hereby authorize my insurance benefits to be paid directly to Bonita Physical Therapy. I authorize Bonita Physical Therapy to release any personal health information necessary to process my insurance claim.

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINT NAME** \_\_\_\_\_