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 Lewisville, Texas 75067
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PATIENT DATA SHEET & INSURANCE VERIFICATION SHEET

Appointment Date: ___/___/___ Appointment Time: ___ Am Pm Intake Completed by: _____ Date: ___/___/___

PATIENT INFORMATION

Social Security #: _____ - _____ - _____ Home Phone: (____) _____ - _____
 Patient Name: (Last) _____ (First) _____ Work Phone: (____) _____ - _____
 Address _____ Birthdate: ___/___/___
 City: _____ State: _____ ZIP: _____ Sex: M or F
 Employer: _____ Occupation/Position: _____ Marital Status: M S W D
 Employer Address: _____ City: _____ State: _____ ZIP: _____
 Reconstructive Surgery? Y or N Accident Type: None W/C Auto Other **Acc/Injury/Onset Date:** ___/___/___
 Acc Details/Reason for Visit: _____ ICD 9 CODE (S): _____

FOR OFFICE USE ONLY

Referring Physician or Profile #: _____ UPIN # _____ FAX (____) _____ - _____
 Physician Phone: (____) _____ - _____ Physician Address: _____
 City: _____ State: _____ ZIP: _____ **Services Ordered:** PT or OT or SP **Body Part:** _____

Emergency Contact: _____ Contact Phone: (____) _____ - _____

RESPONSIBLE PARTY INFORMATION

Social Security #: _____ - _____ - _____ Relation to Patient: Self Spouse Parent Other
 Responsible Party Name: _____ Work Phone: (____) _____ - _____
 Birthdate: ___/___/___ Employer: _____ Sex: M or F

INSURANCE VERIFICATION INFORMATION

Insurance Name: _____/_____ Phone (____) _____ - _____ Ext: _____
 Policy/Claim #: _____ Group # or Name: _____ Insured Name: _____
 Adjuster/Verifier: _____ Phone (____) _____ - _____ Ext: _____ Fax (____) _____ - _____
 Case Manager/PreCert: _____ Phone (____) _____ - _____ Ext: _____ Fax (____) _____ - _____
 Auth # _____ Auth Date: ___/___/___ Auth # of Vests: _____ Expiration Date: ___/___/___
 Billing Address: _____ City: _____ State/ZIP: _____
 PCP Ref/Req: Y or N Pre-cert Req'd: Y or N Max Visits: _____ Max Amount Allowed: \$ _____
 Type of Plan: M/C HMO PPO POS W/C COMM Employer/self – insured? Y or N
 IN NETWORK: deductible: _____ amount met: _____ co ins/copay: _____ OOP: _____
 OUT NETWORK: deductible: _____ amount met: _____ co ins/copay: _____ OOP: _____
 Comments: _____

Patients: Please only fill out the shaded areas of the form.