PATIENT INFORMATION

Patient: Last Name	First	Middle Initial	Birth Date / /	Age	Sex ☐ F ☐ M

Street Address	City	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email Address

Occupation/ Student	Employer/ School Name

Race/Ethnicity:

☐ White/ Caucasian ☐ Pacific Islander ☐ Alaska Native ☐ American Indian

☐ Black/ African American ☐ Non-White Hispanic/ Latino ☐ Asian ☐ Unknown

Who may we thank for referring you to LifeLine Therapy?	Reason you are here:

EMERGENCY CONTACT INFORMATION

Contact: Last Name	First	Home Phone: ( )	Cell Phone: ( )

INSURANCE

Please Indicate Personal Health Insurance

☐ Aetna ☐ Gateway ☐ Medicare ☐ UPMC ☐

☐ BC/BS ☐ Health America/Assurance ☐ Medicaid ☐

☐ Cigna ☐ Highmark ☐ United Health ☐ Other: ___________________

ID #	Group #	Subscriber Name: (If different from patient)	Birth Date / /

Patient's Relationship to Subscriber

☐ Self ☐ Spouse ☐ Child ☐ Other________________

Supplemental/ Secondary Insurance - If any	Subscriber Name & Birth Date -If not patient	ID #	Group #

COMPLETE THE FOLLOWING IF ACCIDENT RELATED

☐ Work Accident ☐ Auto Accident ☐ Other Accident Accident/ Injury Date / /

Insurance Carrier Name	Carrier Billing Address

Claim #	Adjuster Name	Adjuster Phone

Employer Name - If work related	Employer Address	Employer Phone

PHYSICIAN INFORMATION

Referring Physician Name	Office Address

Primary Care Physician Name – If different from referring	Office Address

SIGNATURE of Patient/ Representative/ Parent or Legal Guardian of Minor DATE

X____ _______/______/__________