



PATIENT INFORMATION

Patient: Last Name	First	Middle Initial	Birth Date / /	Age	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Street Address		City	State	Zip Code	
Home Phone ()	Cell Phone ()		Email Address		
Occupation/ Student			Employer/ School Name		
Race/Ethnicity: <input type="checkbox"/> White/ Caucasian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Non-White Hispanic/ Latino <input type="checkbox"/> Asian <input type="checkbox"/> 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: ()
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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 / /
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Patient's Relationship to Subscriber
 Self Spouse Child Other _____

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