North Coast Physical Therapy
3633 Vista Way Suite#101
Oceanside, CA 92056
Ph: 760-729-7298 * Fax: 760-729-7206

PRIMARY INSURANCE INFORMATION

Primary Insurance Company:_____

Policyholder's Name:_____ Policyholder's Date of birth_____

Relationship to Patient: Self Spouse Dependent Parent

Policy Number:_____Group Number:_____

Have you received any previous physical, speech or chiropractic care this year? Yes or No

If so, when and how many visits? _____

Have you received Home Health Care services this year?_____

If so, when is the date you were discharged?_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company:_____

Policyholder's Name:_____

Relationship to Patient: Self Spouse Dependent Parent

Policy Number:_____Group Number:_____

I hereby authorize release of information necessary to file a claim with my insurance company and to assign benefits otherwise payable to me to North Coast Physical Therapy. I authorize North Coast Physical Therapy to release and/or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct.

_____ _____

Signature Date