

AOR Physical Therapy, Inc
2031 W. Alameda Ave., Ste. 200
Burbank, CA 91506
Tel: 818-566-8801 * Fax 818-566-1873

PATIENT INFORMATION FORM

Referring Physician: _____

Name: _____ Age: _____ Date of Birth: _____

Home Address: _____
Street City & State Zip Code

Home #: _____ Cell #: _____ Bus. #: _____ Employer: _____

Business Address: _____
Street City & State Zip Code

Driver's License # & State _____ Social Security #: _____

Spouse's Name: _____ Employer: _____

Business Address: _____ Bus. # _____

Closest relative not living in same household: _____ Phn. # _____

BILLING AND INSURANCE INFORMATION

Please Circle One: *Worker's Comp* *Personal Injury* *Insurance* *Cash*

Name of Insurance Carrier: _____ Date Of Injury: _____

Address: _____
Street City & State Zip Code

Adjuster's Name: _____ Phone Number: _____

Subscriber #: _____ Group #: _____ WCAB Case # _____

Insured Party: *Self* *Spouse* *Father* *Mother* *Other(name and relationship)* _____

Address(of other): _____ Phone Number: _____

Do you have an attorney for this injury (please circle one)? Yes No Attorney Name: _____

Attorney Address: _____ Phone Number: _____

AUTHORIZATION TO PAY PHYSICAL THERAPIST AND FINANCIAL AGREEMENT

I hereby authorize the physical therapist in charge of my case to furnish my insurance company with information concerning my hospital and medical or surgical treatment.

I hereby authorize and instruct my insurance company to pay by check made out and mailed directly to: AOR Physical Therapy, Inc., 2031 W. Alameda Ave., Burbank, CA 91506 the medical and surgical benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not extend my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment. If legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee.

Signature of Insured

Date