Thomas Cleveland, DPT NPI: 1467701979 EIN: 271232027

Patient Information Sheet

PATIENT

Name: _____ DOB: _____ SS#: _____ Sex: _____

Marital Status: ____ (Married, Divorced, Single, Widowed) Home Phone: _____ Cell Phone: _____

Address: _____ E-mail: _____

Permission to Call: Yes No Initials_____ Permission to Call on Cell Phone: Yes No Initials_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Telephone: _____ EPI: _____

Send Claims To: _____

Policy ID#: _____ **Group #:** _____ **Employer:** _____

Name of Insured: _____ Date of Birth: _____ Sex: _____ Relationship: _____

Insured's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Telephone: _____ EPI: _____

Send Claims To: _____

Policy ID#: _____ **Group #:** _____ **Employer:** _____

Name of Insured: _____ Date of Birth: _____ Sex: _____ Relationship: _____

Insured's Address: _____

***Copy of front & back of Insurance card(s) and Driver's License**

BENEFITS Deductible: _____ Co-pay: _____ Co-insurance: _____

Preauthorization required? _____ Agency contact for Preauthorization: _____