Center for Spine & Sport Rehab

6345 S. 56th Street Suite 100
Lincoln NE 68516
402.420.0020 fax 420.420.0014

PATIENT INFORMATION

Name:

Phone: (Home) (Cell)

Address: City/State/Zip:

SSN: Date of birth (mm/dd/yyyy):

Date of onset or injury (mm/dd/yyyy):

Is injury from: Auto Work Other

Have you had physical therapy this year? Yes No

Employer:

Work phone:

Emergency contact:

Emergency phone: Relation:

Referring Doctor:

Primary care Doctor:

How did you hear about our clinic?

Email: *Check box to receive appointment reminders by email*

If you are the primary policy holder and you are filing your claim to your medical insurance and you present us your insurance card you do not have to fill out the Insurance policy section.

If someone other than yourself is the policy holder we require the name, date of birth, social security #, of the primary subscriber.

If you have a Secondary insurance please present us the card and you do not have to fill out the Secondary insurance information section.

INSURANCE POLICY INFORMATION

Primary Insurance Information

Insurance company:

Subscriber's name:

Subscriber's date of birth: Subscriber's relation to patient:

Group number: Identification number:

Secondary Insurance Information (Medicare only)

Insurance company:

Subscriber's name:

Subscriber's date of birth: Subscriber's relation to patient:

Group number: Identification number: