JOANI GELINAS PHYSICAL THERAPY SERVICES
5044 38th Avenue NE ▪ Seattle Washington 98105 ▪ 206 528 5692

Legal Name:_____ Nickname:_____ Date:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Social Security #:_____ Email: _____

Date of Birth: _____ Marital Status: _____ Sex: M F

Referring MD, ND, DC: _____ Emergency Contact: Name: _____
Phone: _____

How did you hear about my office?: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Reason for Visit: Pain Job Related Injury Auto Accident Personal Injury Date of Onset :_____

MEDICAL INSURANCE COVERAGE

	Primary Insurance	Secondary Insurance
Insurance Company Name:	_____	_____
Claims Address:	_____	_____
Insurance Phone No.:	_____	_____
Insurance ID #:	_____	_____
Group #:	_____	_____

Relationship to Insured (Circle One): Self Spouse Child

IF THE INSURED IS **NOT** THE SAME AS THE PATIENT, PLEASE FILL OUT THE FOLLOWING:

Insured's Name: _____ Social Security #: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____ Employer's Address: _____

AUTOMOBILE ACCIDENTS and L & I ONLY:

Insurance Company: _____

Address: _____

Adjuster name and phone: _____

Claim #: _____ Date of Injury: _____

SIGNATURE: _____ DATE:_____

We will gladly bill directly to and accept payment from your insurance company. **It should be understood that all services are charged to you, the patient, who is legally responsible for payment.** Please read billing policy for more details.