☐ Returning Patier	nt													
				(1) PAT	TIENT'S IN	FORMA:	TION							
Patient's L	Family Physician's NAME			Your Email Address										
Pat	1	City, State, Zip			Patient's Telephone Nu		nber Patient's Birth Date							
1 40						H I attent's Birth Bate								
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Detientle Conden	C+. J	+ C+-+	1	Manital Status		1	F)			Ci-1 Ci	4. N	-l	
Patient's Gender Student Status			g M	Marital Status	1.0 . 1	DT.		Employment Status		Patient's Social Security Number			iber	
			S M	D Widowe	a Separated	PT	FT	Retired Not	Not Self					
School Na	er Name			Employer Address			City, State, Zip							
	DC	NOT FILL		PRIMARY PO					ATION AP	OVE				
Primary Insur			rst Name, Middle	I IS THE SA	AME AS THE PATIENT INFORMATION A Primary Insured's Street Address				City, State, Zip					
Primary Insured's Date of Birth Gender			Prima	ry Insured's Teleph	one Number	Prin	mary Insured's Social Security #			Employer's Name				
		()	()			•								
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			(3)	SECONDAR	Y POLICYI	HOLDER	R'S INFO	ORMATION						
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Secondary Insu	e Initial	Initial			Secondary Insured's Street Address			City, State, Zi	.p					
			1	m 1 1 N	,									
Secondary Insured's Date of	of Birth	Gender		Telephone Num		Secon	dary Insure	d's Social Security#		Empl	loyer's Name			
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			(-		RIER INFORMATION Insurance Policy/Group Number Patient's Relationship to Policy H									
Primary Insur	Insurance ID N	Insurance ID Number			Insurance Policy/Group Number			-	-					
									Ind	lividual	Spouse		Child	
Phone #				Policy Holder Name				Group Name	Otl	her:				
Secondary Inst		Insurance ID Number			Insurance	e Policy/Group Numb	er	Patient's Rela	tionship to Po	licy Ho	older			
Pho		Policy Holder Name			Group Name			Individual Spouse Child						
								her:						
Tertiary (3rd) In		Insurance ID number			Insurance Policy/Group Number			Patient's Rela	tionship to Po	olicy Ho	older			
, , ,								lividual	Spouse	-	Child			
Phone #				Policy Holder Name			Insurance Policy/Group Number			ii v i aaaa i	Броивс		Cima	
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WODE	CIID ANCE			AUTO ACCI	DENT IN	T INSURANCE								
WORKER'S COMPENSATION Worker's Comp. Insurance Company Name W				Worker's Compensation Claim Number			Auto Insurance Company Name			Auto Insurance Claim Number				
			Workers	ompensation claim	rvamoer	710	no msurune	insurance company rume		The institute Stain Number				
Address			Accident 1	Date A	ccident State	ent State		Address		Auto Accident Date Accide		Acciden	nt State	
1 Add Sep		riccident	Date 11	cerdent State		710	Address		no ricciacini i	Jule 1	reciden	it Buile		
				(5) DHV	SICIAN IN	FOPM A	TION							
			PROVIDER					APPLICABLE						
Referring Source:									ring Provide	er				
			(6) E	<i>EMERGENC</i>	CY AND RI	ESPONS	SIBLE I	PARTY						
Respon	sible pa	rty to bill f	or services	if not above		Emerg	ency Co	ontact Name:						
Name:							Phone:							
Address:							Relationship:							
☐ Same as policy holder							☐ Same as policy holder							
Orders received for: OT SLP PT(with MC)							POC H&P DC Billing Dx							
Insurance Verified:							One time Eval							
Auth Submitted: Auth Approved:							One time Evai							

Eval Date: OT___SLP__PT___ NIAGARA THERAPY, LLC ID#:00_-___