

PATIENT INSURANCE DATA

J Linn Black Henline, LMP – 425-673-9573 – www.jlinn.net

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: H _____ W _____

SS#: _____ - _____ - _____

DATE OF BIRTH: _____ AGE _____

CURRENT EMPLOYER:

ADDRESS: _____

PHONE: _____

WORK COMP CASES: EMPLOYER AT TIME OF INJURY: _____

ADDRESS: _____

CITY _____ PHONE _____

SEX: MALE : FEMALE: (CHECK BOX) STATUS: SINGLE: MARRIED: SEPARATED: DIVORCED: WIDOWED: ER EMPLOYED: FULL TIME: PART TIME: RETIRED: UNKNOWN: NON-EMPLOYED: F/T STUDENT: P/T STUDENT: CONDITION IS RELATED TO: EMPLOYMENT: AUTO ACCIDENT: OTHER: STATE OF OCCURANCE: GRADUAL: FIRST DR. APPT: OR INJURY: DATE OF INJURY:
--

ANY DATES UNABLE TO WORK?
FROM ____/____/____ TO ____/____/____

EMERGENCY ROOM VISIT? DATE ____/____/____

HOSPITALIZATION?
FROM ____/____/____ TO ____/____/____

PRESCRIBING PHYSICIAN:(incl.credentials, eg "MD")

PHYSICIAN ID #: _____

OF VISITS PRESCRIBED BY DR.: _____

DIAGNOSES _____

—

INSURANCE INFORMATION

PATIENT'S RELATION TO INSURED:
__SELF __SPOUSE __CHILD __OTHER

NAME OF INSURED (if different than patient)

SS # : _____ - _____ - _____ DOB ____/____/____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

INSURANCE CO: _____

PLAN NAME: _____

CLAIMS OFFICE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CLAIM OR CASE #: _____

INSURED'S ID #: _____

POLICY/GROUP #: _____

ADJUSTER: _____

PHONE: _____

OF VISITS AUTHORIZED BY INS: _____

<p align="center">PAYMENT WILL BE EXPECTED AT EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE</p>
--

**IF CASE IN LITIGATION,
ATTORNEY:** _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: _____

<p>IN AN EMERGENCY CONTACT PHONE # _____</p>
