



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Email Address \_\_\_\_\_ SSN \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: Male Female Marital Status: M S D W

Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Emergency Contact Name and Number \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Subscriber Date of Birth:** \_\_\_\_\_

**Subscriber SSN:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_ **Subscriber Date of Birth:** \_\_\_\_\_

**Subscriber SSN:** \_\_\_\_\_

**Assignment of Benefits:** I hereby authorize my insurance benefits to be paid directly to Terrapin Physical Therapy, and I understand I am financially responsible for non-covered services. I also authorize Terrapin Physical Therapy to release any information to process this claim.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_