

Elizabeth Rogers Pilates & Physical Therapy PLLC

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_____ MT BAKER OFFICE

_____ RAVENNA OFFICE

PATIENT INFORMATION

Patient Name: _____

Birth Date: _____ / _____ / _____ LAST FIRST MI Age: _____ Gender: M or F

Address: _____ APT# _____

City _____ State _____ Zip _____

Primary# (____) _____ - _____ C/H Secondary(____) _____ - _____ C/H Work(____) _____ - _____

Email address: _____

Primary Physician: _____ Clinic: _____ Phone: (____) _____

Referring Physician: _____ Clinic: _____ Phone: (____) _____

Is there someone else we can thank for your referral? _____

Emergency Contact: Name: _____ Phone# (____) _____ - _____

INJURY INFORMATION

Chief complaint _____

Injury or Onset Date: _____ Date of surgery (if applicable) _____

Is your injury/condition related to an (circle one) on the job injury / auto accident / other: _____

INSURANCE INFORMATION

PRIVATE HEALTH: _____ eligibility/benefits phone# _____

Subscriber ID# _____ (include all letters/numbers) Group# _____

Subscriber Name: _____ Sub Employer: _____

Patient Relationship: __ self __ spouse __ dependent __ other Subscriber's birthdate: ____/____/____

WORK INJURY: WA Labor and Industries OR Self Insured _____

CLAIM# _____ DOI _____ Have you had previous PT? N / Y # _____

Claim Adjuster Name & contact# _____ (____) _____ - _____ ext _____

AUTO INSURANCE: _____ PIPClaim# _____

What State occurred? _____ Driver / passenger / pedestrian / bicyclist

PIP Adjuster Name & contact #: _____ (____) _____ - _____ ext _____

****please note ERPPT ONLY bill personal PIP benefits **We do not bill "other person's", 3rd party or liability insurance****