

313 E. 8th Avenue
Eugene, OR 97401
Phone: 484-0693
Fax 343-6206

**BODIWISE** PHYSICAL
THERAPY INC.
Maximize Your Potential...
Become Bodywise

1410 Oak Street
Eugene, OR 97401
Phone: 338-7171
Fax 338-7772

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ SEX: M F
ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____ SS#/DL#: _____
PHONE #S: HOME: _____ WORK: _____ CELL: _____
REFERRING PHYSICIAN: _____ REF. PHYS. PHONE: _____
DATE OF ONSET / INJURY: _____ DATE OF INITIAL CONSULT W/ PHYSICIAN: _____
HAVE YOU PREVIOUSLY RECEIVED PHYSICAL THERAPY FOR THIS CONDITION? YES _____ NO _____
NUMBER OF VISITS: _____ DATE INITIATED TREATMENT: _____
IN CASE OF EMERGENCY, CONTACT: _____ PHONE NUMBER: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ INSURANCE PHONE: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER ID #: _____ POLICY/GROUP #: _____
EMPLOYER: _____ EMPLOYER PHONE: _____
CO-PAY: _____ DEDUCTIBLE/OOP: _____ \$ REMAINING: _____
MAIL CLAIMS TO: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ INSURANCE PHONE: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER ID #: _____ POLICY/GROUP #: _____
EMPLOYER: _____ EMPLOYER PHONE: _____
CO-PAY: _____ DEDUCTIBLE/OOP: _____ \$ REMAINING: _____
MAIL CLAIMS TO: _____

MVA / WORK COMP INSURANCE: _____

DATE OF INJURY: _____ CLAIM NUMBER: _____
ADJUSTER: _____ PHONE NUMBER: _____ EXT _____
MAIL CLAIMS TO: _____

I authorize assignment of insurance benefits directly to Bodywise Physical Therapy.
I authorize ADSI to furnish any and all insurance information necessary to process this claim.

PATIENT SIGNATURE

DATE