

# INTEGRATED PHYSICAL THERAPY OF LITTLETON

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LORI BUXTON, P.T.

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

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

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Other

INSURANCE: \_\_\_ Auto \_\_\_ Group/Health \_\_\_ Worker's Compensation \_\_\_ Self-Pay

Name of Insurance \_\_\_\_\_ ID # \_\_\_\_\_

Co-pay: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ Deductible: \_\_\_\_\_

\_\_\_ Please bill for coinsurance \_\_\_ Please bill for deductible

Referring Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Phone numbers \_\_\_\_\_

Relationship to patient \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Address: \_\_\_\_\_

Have you received or are you currently receiving Physical/ Occupational/ Speech Therapy this year? Y / N If yes, where, when, and how many visits? \_\_\_\_\_

IS THIS INJURY ACCIDENT RELATED? Y / N IF YES, DATE OF INJURY? \_\_\_\_\_

## FOR OFFICE USE ONLY

ICD9: \_\_\_\_\_ Diagnoses: \_\_\_\_\_

IS THIS PATIENT APPROVED FOR TMJ DIAGNOSIS? YES NO

Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Authorization #: \_\_\_\_\_ Date(s): \_\_\_\_\_ # of Visits: \_\_\_\_\_