



**Whatcom Physical Therapy
250 G Street
Blaine, WA 98230**

Date ____/____/____

Phone _____ Cell Phone _____

Patients Name _____
Last First M.I

Mailing Address _____
Street City State Zip

Date of Birth ____/____/____ Sex F ____ M ____ Married ____ Single ____ Patient SSN ____-____-____

Place of Employment _____ Occupation _____ Business Phone _____

Spouses Name _____ Spouse SSN ____-____-____

Emergency Contact _____ Relationship to Patient _____ Phone _____

***Person responsible for your account** (*not your insurance company*) _____

Relationship to patient _____ Phone _____ Business Phone _____

Medical Insurance Only

In order to bill your insurance(s) we must make a copy of your insurance card. Thank You

Referring Physician _____ **Family Physician** _____

Do you have medical insurance? Yes ____ No ____

Primary Insurance _____

Secondary Insurance _____

Subscribers Name _____ Date of Birth ____/____/____

L & I or MVA Only

Claim Number _____ Employer at time of injury? _____

Was this an injury? Y ____ N ____ Date of injury ____/____/____ Job related injury? Yes ____ No ____

Briefly explain how the injury occurred _____

Insurance Name and Address _____

Claims Adjustor Name _____ Phone Number _____