ADVANCED BODY THERAPY
HISTORY / INTAKE FORM

PAGE ONE

PATIENT:____

Address:________________________City:____________________State:___ ___Zip:______

DATE OF BIRTH:____________________ HOME PH:________________

OCCUPATION:____________________ WORK PH:________________

HOW LONG:________________________ EMAIL ADDRESS:____________

SPOUSE:__________________________ SPOUSE WORK #:____________

INSURANCE: NAME OF COMPANY______________________________________

Date of Incident____________________ GROUP:__________________

CLAIM / POLICY #:__________________ REF BY:__________________

S. S. #:__________________________ ADJUSTER________________

DOCTOR:________________________ **ATTORNEY:**______________

PHONE #:__________________________ PHONE:__________________

ADDRESS:________________________ **ADDRESS:**______________

CITY:_____________________________ CITY:___________________

STATE:____________ZIP:___________ STATE:________ZIP:________

EMPLOYER:____

COMPANY:_______________________________PHONE:_________________________

SUPERVISOR:____

ADDRESS:__________________________CITY:______________STATE:_______ZIP:_______

NOTIFY / EMERGENCY:_________________________**PHONE:**________________________

Nearest relative, not living with you?____

HOW WILL PAYMENT BE MADE?

AUTO INSURANCE: WORKERS' COMPENSATION: MAJOR MEDICAL: CASH
ATTORNEY LIEN: CREDIT CARD: CHECK:
OTHER:__________________________
CREDIT CARD TYPE:__________CARD #:______________________EXP.DATE:__________