Synergy Therapeutic Group

First Contact & Payment Verification

	Date of Contact	**Staff Name**		**Appt. Time**	**Appt. Date**
Condition	**Area of pain/problem**			**Date pain/problem began**	
	Mechanism of Injury (cause)		**□ Work □ Auto □ Other**	**Date of similar pain/problem in past**	
	Married Single Widowed Divorced Other: _____ **Impairments? □ Sleep □ Bathroom □ Sit □ Walk □ Other: _____**			**□ Worsening □ Better □ Same**	**□ Hospitalized □ Missing work Since when?**
Patient Info	**Patient Name (Last, First) PT __ OT ____ BOTH _____**		**Age**	**Date Of Birth**	**□ Male □ Female**
	Home Phone	**Other Phone**	**Email**		
	Street Address		**City**		**State & Zip**
	How did you hear about us?		**Social Security #**		
	Employer Name		**Occupation**		**Employer Phone**
	Emergency Contact Name		**Contact Relationship**		**Emergency Phone**

Payment Information	**PRI WC LIEN MC AUTO SELF-PAY (discount/CC info to reserve) PAY PLAN other:**				
	Primary Insurance #:	**Phone**		**Primary ID#**	**Primary Group #**
	Secondary Insurance #:	**Phone**		**Secondary ID#**	**Secondary Group#**
	Subscriber Name (if other than self)	**□ Parent □ Spouse □ Other**	**DOB**	**Referring Physician & Phone Number**	
	(WC only) Claim Number	**Adjuster Name**		**Phone #**	**Date of injury**

Notes:

Dedicated To Clinical Excellence