

# Campus Physical Therapy Center

901 Campus Drive Ste 213 Daly City, CA 94015 Tel: (650) 994-7800 Fax: (650) 240-1834

I learned about this office from: Physician Relative Website Google Yahoo MSN Facebook Radio/TV Other

**Patient Information:** [please provide a copy of your driver license]

Mr. Mrs. Ms. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Age \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cel Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Soc.Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female Marital Status: Married Single Other \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Driver's License No.: \_\_\_\_\_ State \_\_\_\_\_  
E-Mail: \_\_\_\_\_ @ \_\_\_\_\_ Can we use your Email to sent you information: yes no  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Responsible Party Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Age \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Soc.Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female Marital Status: Married Single Other \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Driver's License No.: \_\_\_\_\_ State \_\_\_\_\_  
E-Mail: \_\_\_\_\_ @ \_\_\_\_\_ Can we use your Email to sent you information: yes no

**Primary Insurance and Policy Information:** [please provide a copy of your insurance card]

Insurance Company Name: \_\_\_\_\_  
Adjustor Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Claim No: \_\_\_\_\_ Authorization No: \_\_\_\_\_  
Policy No: \_\_\_\_\_ ID No: \_\_\_\_\_  
Annual Deductible: \$ \_\_\_\_\_ Deductible Paid: \$ \_\_\_\_\_ Co-payment: \$ \_\_\_\_\_ Other Payment \$ \_\_\_\_\_

**Secondary Insurance and Policy Information:** [please provide a copy of your insurance card]

Insurance Company Name: \_\_\_\_\_  
Adjustor Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Claim No: \_\_\_\_\_ Authorization No: \_\_\_\_\_  
Policy No: \_\_\_\_\_ ID No: \_\_\_\_\_  
Annual Deductible: \$ \_\_\_\_\_ Deductible Paid: \$ \_\_\_\_\_ Co-payment: \$ \_\_\_\_\_ Other Payment \$ \_\_\_\_\_

**Workers Compensation Insurance and Claim Information:** [please provide a copy of the claim filed]

Insurance Company Name: \_\_\_\_\_  
Adjustor Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Claim No: \_\_\_\_\_ Authorization No: \_\_\_\_\_  
Policy No: \_\_\_\_\_ ID No: \_\_\_\_\_

**Motor Vehicle Insurance and Claim Information:** (This is your own car insurance. Do not provide a third party)

Motor Vehicle Insurance Company Name: \_\_\_\_\_  
Adjustor Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Claim No: \_\_\_\_\_ Policy No: \_\_\_\_\_ ID No: \_\_\_\_\_  
Do you have Medical Coverage: Yes No Medical Payment Coverage: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_

**Employer Information:**

Company Name: \_\_\_\_\_ Contact Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_ Fax Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_