

BOTHELL PEDIATRIC & HAND THERAPY

18504 Bothell Way NE Bothell, WA 98011 425-481-1933 Fax 425-481-9371

PATIENT INFORMATION – Please Print Clearly

Date of Initial Visit: _____ / _____ / _____

Patient Name: _____ DOB: _____
(Last) (First) (Middle Initial)Patient Social Security Number: _____ Male Female Age: _____

Parent(s) or Guardian (if patient is a minor): _____

Address: _____
(City) (State) (Zip Code)

Hm Phone: (_____) _____ Cell Phone: (_____) _____

Wk Phone: (_____) _____ xt _____ → Work phone is for: _____

E-mail: _____ Patient Marital Status: Single Married Other ChildIs the Patient Employed: Yes No Full-time Part-time

Employer: _____ Occupation: _____

Is the Patient a Student Yes No Grade: _____ School: _____**REFERRAL INFORMATION**

How did you hear about us? _____

Referring Doctor: _____ Facility: _____ Ph # _____

Primary Care Doctor: _____ Facility: _____ Ph# _____

INSURANCE INFORMATION – In order to bill your insurance(s), we must have a copy of your card(s)

Primary Ins Co: _____ Secondary Ins Co: _____

Verification Ph #: _____ Verification Ph #: _____

Policy ID #: _____ Policy ID #: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's SS#: _____ Subscriber's SS#: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

L & I / VOCATIONAL REHAB INFORMATION

Name of Claims Manager: _____ Phone: (_____) _____

Claim #: _____ Date of Injury: _____ / _____ / _____ ICD-9: _____

INJURY INFORMATIONCondition is related to Work Auto Home Birth Sports Other None

Date of Injury / Onset of Condition: _____ Diagnosis/ICD-9: _____

Body Side Affected: Right Left Both Body Part Affected: _____**EMERGENCY CONTACT**

Name: _____ Phone: (_____) _____

Address: _____
(City) (State) (Zip Code)