Timothy V. Sandell, M.D. THE PEAK PHYSICAL MEDICINE

Date:_____

Jamie L. Case, MS, PA-C

Patient Information

Full Name_____ Sex: ☐ Male ☐ Female DOB:_____

Address_____ City_____ State_____ Zip_____

Best # to reach you at during daytime _____Cell Home Work (circle one)

Secondary Phone # _____ Cell Home Work (circle one)

Email _____

Patient Social Security # _____ Marital Status: Married Divorced Single Widowed

Pharmacy_____Phone _____Fax_____

Primary Physician _____Phone_____Fax_____

Physician(s) you would like us to send visit notes to (if any):_____Fax_____

Insurance Information

PRIMARY INSURANCE (Payments including insurance co-payments are due at time of service.)

Insurance Company_____ Insurance Phone Number _____

Subscriber's Name_____ Birth date_____

Member # _____ Group # _____ Specialty Co-pay _____

SECONDARY INSURANCE

Insurance Company_____ Insurance Phone Number _____

Subscriber's Name_____ Birth date_____

Member # _____ Group # _____

WORKERS COMPSENATION INJURY

Insurance Company_____

Claims Address_____

Date of Injury _____Claim Number _____

Employer (at time of injury)_____

Adjuster's Name _____ Phone _____

AUTO ACCIDENT INJURY

Lien Company _____

Date of Injury _____ Claim Number _____