Vivie Therapy
REBUILDING YOUR BODY, MIND AND SPIRIT BACK-TOGETHER
8818 Saturn St. Los Angeles CA 90035
(310) 623-4444 www.Vivie.com

New Patient Information

Date: _____/_____/_____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____ DL#:_____

Phone: Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Other: ( )_____

Email: _____

[ ] Yes [ ] No - Please check the appropriate box regarding receiving updates and information on the exciting events and specials that are being offered here at PTPT.

Date of Birth_____/_____/_____ S.S.N. _____-_____-_____ Sex [ ] M [ ] F

In Case of Emergency: _____ Phone: ( ) _____

Have you had PT, OT, Speech, Chiro or Acupuncture this year? [ ] Yes [ ] No

If so, how many visits? _____

Insurance Information

Insurance Carrier: _____ Phone: ( ) _____

Insured Name: _____ ID#: _____

Insured Date of Birth: ___/___/_____Group #: _____ Policy #: _____

Adjustor Name: _____ Phone: ( ) _____

Claim #: _____ Insured Relation To Patient: _____

Secondary Insurance Carrier: _____ Phone: ( ) _____

Insured Name: _____ ID#: _____

Insured Date of Birth: ___/___/_____Group #:_____ Policy #:_____

Referring Physician:

Doctor's Name: _____

Phone: Work ( ) _____ Fax ( )_____

Diagnosis: _____Date of Last Visit to MD: ____/____/_____

Lien Information:

Date of Injury: ____/___/____

Referring Attorney: _____ Phone: ( ) _____

Attorney Address: _____

Referred By: ❒ Doctor _____ ❒ Friend _____

❒ Patient _____ ❒ Other _____