Body Wise Therapy, P.C.

2504 South 119th Street
Omaha, NE 68144-2975

Phone: (402) 932-8686
Fax: (402) 932-8677

Demographic Information:

Patient Information:	
Name: _____	SS#: _____
Address: _____	DOB: _____
Address: _____	Marital Status: _____
City, St, Zip: _____	Gender: _____
Home Phone: _____	Alt. Phone: _____

Guarantor Information:	
Name: _____	SS#: _____
Address: _____	DOB: _____
Address: _____	Relationship: _____
City, St, Zip: _____	Gender: _____
Home Phone: _____	Alt. Phone: _____

Emergency Contact Information:	
Name: _____	Phone: _____

Employer Information:	
Name: _____	Phone: _____
Address: _____	
Address: _____	
City, St, Zip: _____	

Insurance Information:

Primary Insurance Information:

Company: _____ Phone: _____

Address: _____

Address: _____

City, St, Zip: _____

PolicyHolder Name: _____

Policy Number: _____ Group #: _____

Please bring your Insurance Card with you to your Appointment.
We will make a copy when you arrive.

Demographic Information: (Con't)

Insurance Information:

Secondary Insurance Information:

Company: _____ Phone: _____

Address: _____

Address: _____

City, St, Zip: _____

PolicyHolder Name: _____

Policy Number: _____ Group #: _____

Please bring your Insurance Card with you to your Appointment.
We will make a copy when you arrive.

Accident Information:

Please Complete this Section if you had an Accident

How did it happen? ☐ Auto ☐ Work ☐ Other (Location) _____

Accident Date: _____ Insurance Company: _____
(Worker's Comp or Auto)

Attorney's Name: _____ Address: _____

Address: _____ City, St, Zip: _____

City, St, Zip: _____ Insurance Phone: _____

Attorney Phone: _____ Name of Insured: _____

Claim Number: _____ Adjuster Name: _____

Disclaimer:

I certify that the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, there of, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Body Wise Therapy, P.C. for services rendered. I authorize payment for these services be paid directly to Body Wise Therapy, P.C.

Signature: _____ Date: _____