

Andrus Physical Therapy  
Pediatric Center  
804 West Park Avenue, Bldg C  
Ocean, NJ 07712  
Phone: (732) 493-1166 Fax: (732) 493-1188  
**INSURANCE INTAKE FORM**

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female      Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

***INSURANCE INFORMATION***

Primary Insurance Company: \_\_\_\_\_

Policy Holder Name (if different from patient's) \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holder Name (if different from patient's): \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

**MOTOR VEHICLE OR WORKMANS COMPENSATION**

Please fill out the following information if your claim involves a motor vehicle accident or workman's compensation claim.

Insurance Company Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Date of Accident/Injury: \_\_\_\_\_

Claim # \_\_\_\_\_ Case Manager Name \_\_\_\_\_

**I HAVE READ THE ABOVE STATEMENTS AND HAVE ANSWERED THEM TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE TO IMMEDIATELY NOTIFY Andrus Physical Therapy, LLC OF ANY CHANGE(S) IN MY INSURANCE COVERAGE. I ALSO UNDERSTAND THAT INSURANCE COVERAGE AND/OR AUTHORIZATION DOES NOT GUARANTEE PAYMENT OF SERVICES. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.**

Signature of patient or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_