Health Enhancement Therapies
Saint Michael, MN

INSURANCE INFORMATION

Date: _____ Check one: Auto Accident_____ Work-related injury _____

Client's First Name: _____ M.I.:_____ Last Name:_____

Address: _____

Social Security#: _____ D.O.B._____ Marital Status: _____

Employed: Full Time_____ Part Time _____ Retired _____ Self-employed _____ Not employed _____ Student _____

Name & Address of Current Employer: _____

_____

Work Comp Cases: Employer name and address at time of injury: _____

_____

Insurance Company: _____

Ins. Co. Address:_____ City: _____

State: _____Zip: _____ **Phone:** _____

Insurance Contact Person: _____ Claim Number:_____

Policy Number: _____Group or I.D.#: _____

Claims Office Address:_____

City: _____ State:_____ Zip:_____

Subscriber's First Name: _____ M.I.:_____ Last Name:_____

Subscriber's S.S.#: _____ D.O.B.:_____

Employer Name/Address:_____

Referring Dr. _____ I.D.# _____

Ref Dr. Address: _____

Ref. Dr. Phone #:_____ Is this your Primary Care Provider? _____

If No, please provide name: _____

Doctor's Diagnosis of Injury:_____

ICD-9 Code (s):_____

# of Visits Prescribed: _____ # of Visits Authorized by Insurance: _____

Date of Injury: _____ Injury onset: Gradual _____ Sudden _____

IF ANY: Dates unable to work: _____ Dates of Hospitalization of emergency room visit: _____

If case in Litigation: Name of Attorney:_____ Phone: _____

Address: _____

Emergency Contact: _____