Advanced Therapy Center of Delray Beach
Family Wellness Centers, Inc.
15127 Jog Road, Suite 210, Delray Beach, FL 33446

Personal Information

Last_____; First_____; MI_____; Sex_____

Street Address_____; City_____; State_____

Zip Code_____; Social Security Number _____

Home Phone (_____)-_____-_____; Office Phone (_____)-_____-_____; Student?____ Married? ____

Cell Phone; (_____)-_____-_____(IMPORTANT- CELL PHONE CARRIER?)_____

e-mail _____@_____

Date of Birth _____/_____/_____; Occupation_____

Driver License Number _____; State of Issue_____

Financial Information

Primary Insurance Co. _____Effective Date____/____/_____

Type (HMO. PPO, Auto, Worker Comp)_____; ID#_____

Insurance Co. #2 _____Eff.____/_____/_____; Type_____

Covered by VA or Black lung Benefits?_____; Who's Financially Resp. (Self/Wife's Insurance/other)_____; Lawyer Info (If Applicable) Name_____

Address_____; City_____; State_____

Phone Number (____)-_____-_____.

Claim Information

Auto Accident? _____ ; Work Related?_____; Other?_____; No Injury (skip section)_____ _

Claim Number_____; Date of Injury : ____/____/_____

Date of 1st visit for this injury ____/____/_____; Date of Similar Symptoms; ____/_____/_____

Are you employed?_____; Company name _____

If injured, work related? _____; If Yes, authorization number _____

State where accident occurred_____ ; Hospitalized?_____ ;

If applicable, dates you are unable to work ____/____/_____ through ____/____/_____ or present.

Referral Information

Referring Physician Name _____ Type of Doctor ; _____

Other Referral Source Name_____

Phone Number of Referral Source (___)-_____-_____; e-mail:_____@_____

Your Doctor's Street Address _____; City _____

State _____; Zip Code _____