SOUND BODY
REHABILITATION INC
BUILDING A BETTER YOU

Patient name: _____ Today's date: _____

(Last) *(First)* *(Middle Initial)*

Date of birth: _____ Age: _____

Home address: _____

Mailing address: _____

Home phone: (_____) _____ May we leave a message? ☐Yes ☐ No

Cell phone: (_____) _____ May we leave a message? ☐ Yes ☐ No

Work phone: (_____) _____ May we leave a message? ☐Yes ☐ No

Email address: _____ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency contact and phone: _____

Name of parent/ guardian: _____

(Last) *(First)* *(Middle Initial)*

Primary Insurance Co. _____

Insurance Co. phone # _____

ID # _____ Group ID # _____

Name of insured (if not the client) _____

Date of birth of insured _____ SS# of Insured _____

Insured's Employer _____

Secondary Insurance Co._____

Insurance Co. phone # _____

ID # _____ Group ID # _____

Name of insured (if not the client) _____

Date of birth of insured _____ SS# of Insured _____

Insured's Employer _____

Worker's Compensation OR Automobile Insurance _____

Policy/Claim Number _____ Date of Injury _____

Contact Name and Number _____

Employer at time of work injury _____

Attorney Name and Number _____

**Please provide us with your private insurance information as well.*

4459 SE Mile Hill Drive, Port Orchard, WA 98366 Phone 360-769-5944/Fax 360-769-6250