Patient Information

John L. Bray, ATC P.O. Box 7112 Novi, MI 48376

Today's Date: _____ Referred By: _____
Name: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____
Billing Address (If different than above):

_____
Name of Spouse: _____
Place of Employment: (or if minor, list parent or guardian):

In case of emergency notify:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: _____ Work: _____

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____Contract Number: _____
Plan Code: _____ Group Number: _____
Name of Insured: _____
Relationship to Patient: _____
Insured's Address if different than Patient's:
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Other Insurance Coverage: _____
_____

I understand that John L. Bray does not participate in HMO and out-of-network insurances. Also, I understand that all therapy charges are payable at the time of each visit.

Signature: _____ Date: _____

Print Form