Stacy Pettit, OTR/L, MBA

2401 E. 42nd Ave., #205
Anchorage, AK 99508
907-561-6111

D & W REHAB, INC

PATIENT INFORMATION		
Last Name:		
First Name:	Middle Name:	Nickname:
Current address:		
City:	State:	ZIP Code:
Date of Birth:	Social Security Number:	Email*:
Cell Number:	Home Number:	Fax:

EMPLOYMENT INFORMATION	
Current employer:	
Employer address:	How long?

EMERGENCY CONTACT
Name of a relative not residing with you:
Phone Number:
Relationship:

SPOUSE'S INFORMATION	
Name:	Phone Number:
Date of Birth:	
SSN:	

MEDICAL TREATMENT/HISTORY		
Referred by:		
Reason for visit today:		
Visit is related to on-the-job injury: Yes __ No ___	Work Comp Carrier:	Claim #:
Visit is related to vehicle accident? Yes __ No __	Insurance Name:	Policy #:
Treating Physician:		
Please describe previous treatment for this condition, including medication information, chiropractic/physical/occupational therapy treatments:		

OTHER CONCERNS OR DISABLING FACTORS

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WORKERS COMPENSATION INFORMATION (complete if applicable)	
Workers Compensation Carrier name:	Claim Number:
Adjuster's Name:	Phone number:
Date of Injury:	

INSURANCE INFORMATION ***You can fill this information in or provide us your card and we will copy info***	
Primary Insured Information	
Last Name:	First Name/Middle Initial:
Address:	City/State/ZIP:
Relationship to Insured (check one): __ Self __ Spouse __ Child __ Other	
Gender: Female __ Male __	
Insured's Date of Birth:	Home Phone Number:
Name & Address of Insurance Company:	
Insured Identification Number:	
Group #:	
Effective Date:	
Employer Sponsoring Plan:	
Secondary Insured Information	
Last Name:	First Name/Middle Initial:
Address:	City/State/ZIP:
Relationship to Insured (check one): __ Self __ Spouse __ Child __ Other	
Gender: Female __ Male __	
Insured's Date of Birth:	Home Phone Number:
Name & Address of Insurance Company:	
Insured Identification Number:	
Group #:	
Effective Date:	
Employer Sponsoring Plan:	

MEDICATIONS – PLEASE LIST		

SIGNATURES	
Signature of applicant:	Date: