



**PHYSICAL THERAPY
OCCUPATIONAL THERAPY**

COMMUNITY MEDICAL GROUP
OF RIVERSIDE INC.

4444 MAGNOLIA AVENUE
RIVERSIDE CA 92501
(951) 274-3424
(951) 274-3518 FAX

SCHEDULED APPT: _____

TIME: _____

THERAPIST: _____

EXAM AND TREATMENT APPOINTMENT INFORMATION

PATIENT NAME: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ DOB: _____ MARITAL STATUS: _____

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ OCCUPATION: _____

PHYSICIANS NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

DIAGNOSIS: _____ ICDA# _____

INSURANCE CARRIER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

DATE OF INJURY: _____ CLM# _____

ADJUSTER AUTHORIZING TREATMENT: _____

COMMENTS: _____

FORM COMPLETED BY: _____ DATE: _____