



TODAY'S DATE _____

PATIENT INFO.

Name: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

Guarantor: _____

REFERRING PHYSICIAN INFO

Name: _____

Physician Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () _____

Fax: () _____

Main Contact Person: _____

INSURANCE

Insurance Company: _____

Policy Number: _____

Phone: () _____

Authorization Number: _____

PRIMARY CARE PHYSICIAN (If different from above)

Name: _____

Address: _____

City: _____ Zip: _____

Phone: () _____

VIBRANTCARE CLINIC LOCATION: Grand Prairie

2801 Osler Dr., Bldg B, Suite 122, Grand Prairie, TX 75051

☐ EVAL & TREAT _____ ☐ FREQ & DUR. _____ /PER WK X _____ /WKS

- ☐ Orthopedic – Adult
- ☐ Orthopedic – Pediatrics
- ☐ Sports Physical Therapy
- ☐ Musculoskeletal Injuries

- ☐ Dry Needling
- ☐ Cupping
- ☐ Vestibular
- ☐ Fall Risk

- ☐ Workers' Comp
- ☐ Work Conditioning
- ☐ Concussion Rehab

☐ Other: _____

Diagnosis / ICD-10 / Special Instructions: