



PATIENT INFORMATION

Name _____ Social Security Number _____

Address _____ City & Zip Code _____

Home Phone # _____ Work Phone # _____ Birth Date _____ Age _____

Phone number to be used as the primary contact number _____

Email address _____

Sex M / F (circle one) Marital Status _____ Spouse's Name & Work # _____

Responsible Person's Name, Address & Phone # (for patient's under 18) _____

Date you last saw your referring and/or primary physician _____

Referring Physician _____
(First and last name) (City)

Primary Physician _____

Employer Name _____ Phone Number _____

Address _____ Occupation _____

Have you had physical therapy or chiropractic care in the past year? _____

How did you hear about us? _____ Doctor _____ Advertisement
_____ Friend (provide name) _____

<p>INSURANCE INFORMATION: <i>Please give your Insurance Cards to the Receptionist for verification.</i></p> <p>Is this accident related YES / NO AUTO / WORKERS COMP Date of INJURY _____</p> <p>Primary Insurance _____ Secondary Insurance _____</p> <p>Are you the Subscriber (holder) of the Insurance Policy YES / NO</p> <p>If not, please complete: Subscriber's Name _____ Date of Birth _____</p>

AUTHORIZATION AND RELEASE

I certify that the information provided on my health history has been provided as accurately as possible. I authorize the physical therapist to release any information, including diagnosis and records of any treatment or examination rendered to my child or me during the period of such physical therapy care, to third party payers and/or health practitioners. I authorize and request my insurance company, should I have insurance and if they will do so, to pay any insurance benefits directly to the treating physical therapist. I agree to be responsible for the payment of all services rendered on behalf of my dependents, or me and also for any charges, which may arise from collection of that fee.

Patient Signature (or Guardian)

Date