Appointment Date: _____ Appointment Time: _____ NP: _____ OP: _____ Therapist: _____

PATIENT INFORMATION

FULL NAME: _____ Nickname: _____

PRIMARY PHONE: _____ **SECONDARY PHONE**: _____

Mailing Address: _____

Physical Address: _____ **EMAIL ADDRESS:** _____

MALE_____ **FEMALE** _____ **Married**_____ **Single** _____ **Widowed** _____ **Divorced**_____

BIRTH DATE: _____/_____/_____Age: _____ **SOCIAL SECURITY:** _____

Employer:_____**Work Phone**: _____

Employer Address: _____
Street City State Zip Code

Injury/Description: _____ Date of Injury: _____ HM/WK/AUTO/SPORTS/OTHER_____

Ref. Dr: _____ **Primary Dr:** _____
Have you received physical therapy this calendar year elsewhere? Yes _____ No _____
IF YOU ANSWERED YES TO THE ABOVE QUESTION WHERE IT WAS RENDERED? _____ WHEN? _____
Have you received Home Health Care in last six months? Yes _____ No _____

X-Ray: No Yes Place/Doctor:_____
MRI: No Yes Place/Doctor:_____
Surgery : No Yes Place/Doctor:_____

EMERGENCY CONTACT: _____ **PHONE #:** _____

SPOUSE INFORMATION

His/Her Name:_____ Birth Date: ____/____/____ Social Security #:_____

Employer:_____ Work #: _____

PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT (IF UNDER 18 YEARS OLD) NO ABSENT PARENT BILLING

Parent:_____ Relationship:_____ Phone #: _____

Birthdate: _____ Social Security #_____ Work# _____ Cell # _____

Release of information (please check one):

- □ I authorize the release of medical information to the following persons. (i.e.: wife, children, etc.)
  1) _____ 2) _____ 3) _____
- □ I do ***not*** wish to release information to any persons other than myself.

_____ _____

PATIENT OR GUARDIAN SIGNATURE **DATE**

Insurance Information

PATIENT/SUBSCRIBER NAME:

PRIMARY INSURANCE: _____ **Insurance Phone** _____

PRIMARY INSURANCE ADDRESS: _____

____

Subscriber Name_____**Birthdate:** _____**SS#:** _____

Employer: _____ **Phone:** _____

Subscriber ID _____ **Claim**_____ **Group** _____

Type of Benefit_____ Policy Effective Date _____ Date of Injury _____

Individual Deductible_____/_____met Family Deductible _____/_____met Copay _____

Paid at_____ of INS Allowable Individual Max OOP: _____ Family Max OOP: _____

Max Payable Allowed per day _____ Max Payable Allowed per Benefit Year _____

NUMBER OF VISITS MAX ALLOWED _____

Combined with: occupational speech respiratory massage cardiac cognitive chronic pain other: _____ none

AUTHORIZATION _____ **RX/SCRIPT REQUIRED YES** _____ **NO** _____

Notes_____

VERIFIED BY/CM _____ DATE_____ FAX _____

CURRENT HEALTH SAVINGS ACCOUNT (HSA): YES_____ **NO** _____ **AMOUNT $** _____

SECONDARY INSURANCE: _____

Subscriber Name_____**Birthdate:**_____**SS:** _____

Employer:_____ Phone _____

Subscriber ID_____ **Claim**_____**Group** _____

Type of Benefit_____ Policy Effective Date _____ Date of Injury_____

Individual Deductible_____/_____met Family Deductible _____/_____met Copay _____

Paid at_____ of Ins Allowable Individual Max OOP:_____ Family Max OOP: _____

Max Payable Allowed per day _____ Max Payable Allowed per Benefit Year _____

NUMBER OF VISITS MAX ALLOWED _____

Combined with: occupational speech respiratory massage cardiac cognitive chronic pain other: _____ none

AUTHORIZATION #_____ **RX/SCRIPT REQUIRED YES** _____ **NO** _____

Notes_____

Verified by/CM _____ Date_____ Fax # _____

CURRENT HEALTH SAVINGS ACCOUNT (HSA): YES_____ NO _____ AMOUNT **$**_____