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

PATIENT INFORMATION

Full Name: _____ Nickname: _____

Primary# _____ **Secondary#** _____

Mailing Address: _____
Street City State Zip Code

Physical Address: _____
☐Same Street City State Zip Code

Please check appropriate space: Male _____Female _____

Birthdate: _____/_____/_____ **Social Security#:** _____

Employer: _____ Work**#:** _____

Injury/Description: _____ **Date of Injury:** _____ **Work/Auto/Other:** _____

Referring 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? Yes_____ No_____ When? _____ Have you been discharged? _____

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

Emergency Contact: _____ **Relationship:** _____ **Phone#**_____

SPOUSE INFO OR PARENT/GUARDIAN RESPONSIBLE FOR ACCOUNT (IF UNDER 18 YEARS OLD)

Spouse/Parent: _____ **Relationship**: _____ **Phone#** _____

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

NO ABSENT PARENT BILLING

Release of Information (Please Check One):

☐ I (patient) authorize the release of medical information to the following persons. (ie: spouse, children, etc.)

1) _____ 2) _____ 3) _____

☐ I (patient) ***do not*** wish to release information to any persons other than myself.

_____ _____

PATIENT SIGNATURE (parent/guardian sign if patient is a minor) **Date**

Insurance Information

Patient Name

Primary Insurance_____ **Insurance Phone** _____

Mail claims to_____

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

Employer_____**Phone#**_____**Ext**_____

Subscriber ID (Alpha pre)_____ **Group#** _____**Claim#**_____

Policy Effective Date_____ **Date of Injury**_____ **Date of Surgery**_____

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_____ **HSA**? Yes_____No_____Amount? _____

Combined with: occupational speech respiratory massage cardiac cognitive chronic pain other: _____none

Authorization#_____ **RX/Script Required: Yes**_____ **No**_____

NOTES_____

Verified by/CM_____ **Date**_____ **Fax#**_____

Supplement/Secondary Insurance_____

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

Employer_____**Phone#**_____**Ext**_____

Subscriber ID (Alpha pre)_____ **Group#**_____**Claim#**_____

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#**_____