EXCELLENCE IN PHYSICAL THERAPY

Name: _FIRST_____MI:_____LAST:_____

ADDRESS :STREET:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE: _____WORK PHONE:_____CELL:_____

AGE:_____DATE OF BIRTH: _____

EMPLOYER:_____ OCCUPATION:_____

LAST DAY WORKED: _____

EMERGENCY CONTACT:_____ PHONE #_____

REFERRING PHYSICAN:_____PRIMARY PHYSICIAN: _____

DIAGNOSIS: _____ DATE OF INJURY_____
DATE OF SURGERY: _____

Have you seen a physical therapist this year? Yes__No__ If yes, how many visits this year?_____

Are you seeing a chiropractor? Yes__No__ If yes, how many visits this year?_____

Is this a work related injury? Yes__ No__ Automobile Accident? YES__ NO___

INSURANCE CARRIER:_____POLICY/CLAIM #:_____

NAME OF INSURED:_____DOB:_____RELATIONSHIP TO PATIENT:_____

MAY WE OBTAIN RELEVANT X-RAY/MRI.CT SCAN REPORTS? Yes_____ No____

_____

I certify that the above information is correct to the best of my knowledge. I understand and agree that I am personally responsible for full payment of all physical therapy services rendered to me. I herby transfer/assign payment of any physical therapy insurance benefits direct to Excellence In Physical Therapy and authorize release of any information regarding my treatment that is required by my insurance carrier to obtain such a payment.

SIGNATURE:_____DATE:_____

OFFICE USE ONLY INITIAL APPOINTMENT: _____ DATE INITIATED: _____

RESCHEDULED APPOINTMENT: _____ INITIATED BY: _____