EXCELLENCE IN PHYSICAL THERAPY

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PATIENT INFORMATION

FIRST: _____ MI: _____ LAST: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

HOME: (_____)_____ WORK: (_____)_____ CELL: (_____)_____

EMAIL ADDRESS: _____

AGE: _____ DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____

EMPLOYER: _____ OCCUPATION: _____

LAST DAY WORKED: _____

EMERGENCY CONTACT: _____ PHONE: (_____)_____

REFERRING PHYSICAN: FIRST: _____ LAST: _____

PRIMARY PHYSICIAN: FIRST: _____ LAST: _____

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? _____

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

*Adjuster Name: _____ Phone (_____)_____

INSURANCE CARRIER: _____ POLICY/CLAIM #:_____

NAME OF INSURED: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ SUBSCRIBER: _____DOB:_____

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 hereby 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:_____