

The Physical Therapy Clinic

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone () - _____ Work Phone () - _____ Cell Phone () - _____
Date of Birth / / SSN - - Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone () - _____

Employer

Name _____ Phone () - _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury / / Last Physician Visit / /
Referred By _____ Primary Care Physician _____
Latest Referral Information _____ Motor Vehicle Accident _____
Latest Plan of Care _____ That occurred in: _____
Notes: _____

Primary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Information Form.

I acknowledge by my signature that I have been made aware of the PRIVACY PRACTICES of this clinic.

Signature: _____ Date: _____