PREFERRED PHYSICAL THERAPY

PATIENT INFORMATION

Last Name:_____ **First Name**:_____ **MI**:_____ **SEX**:_____

DOB:_____/_____/_____ **Age**:_____ **SS#** _____-_____-_____ **Are you married?** ☐Yes ☐No
Address:_____ **City/ State/ Zip**:_____

Home Phone (_____) _____ **Cell Phone** (_____) _____ **Work Phone** (_____) _____

Can we leave messages: On your answering machine ☐Yes ☐No

With another individual on these above numbers? ☐Yes ☐No If yes who_____
E-Mail Address: _____

Preferred Method of Appt Reminders: ☐Text ☐E-mail
Primary Care Physicians Name:_____
Occupation:_____ **Employer**:_____

Employer Address: _____ **City/ State/ Zip**:_____

Did this Injury occur on the job? ☐Yes ☐No If Yes, please Provide Human Resource contact_____

Have you had Physical/Occupation/Speech Therapy THIS YEAR? ☐Yes ☐No If Yes, please tell us how many visits:_____

EMERGENCY CONTACT INFORMATION

Last Name:_____ **First Name**:_____ **Phone** (_____) _____

Address:_____ **City/ State/ Zip**:_____

Relationship to the patient: _____

INSURANCE INFORMATION (If you have a second insurance please also fill out reverse side)

Name of Insured (if different from the patient): _____ **Insured DOB**:_____/_____/_____

Insured SS# _____-_____-_____ **Insured Relationship to Patient**:_____

Insured Employer:_____

Insurance Company Name:_____ **Policy #:**_____

GROUP #:_____

FOR RAPID PROCESSING OF YOUR CLAIMS PLEASE PROVIDE CURRENT INFORMATION.
PLEASE LET US KNOW, WHEN THERE ARE ANY CHANGES.

I do hereby consent to medical treatment/ physical therapy and the release of any medical or other information that may be necessary for either medical care/ physical therapy or in processing applications for financial benefits. I also authorize direct payment of medical/ physical therapy benefits to Preferred Physical Therapy for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

_____ _____
Patient Signature Date

_____ _____
Patient Guardian Signature (if applicable) Date

INSURANCE INFORMATION

Name of Insured (if different from the patient): _____ **Insured DOB**:_____/_____/_____

Insured SS# _____-_____-_____ **Insured Relationship to Patient**:_____

Insured Employer:_____

Insurance Company Name:_____ **Policy #:**_____

GROUP #:_____

AUTO INSURANCE INFORMATION (complete only if injury is due to an AUTO ACCIDENT)

Please provide copy of insurance card.

Insurance Co. Name._____ **Phone** (_____)_____

Claim Number_____**Adjustor's Name**_____

Address:_____ **City/ State/ Zip**:_____

LEGAL REPRESENTATION (complete only if you are under legal representation for this injury)

Attorney Name_____ **Phone** (_____)_____

Address:_____ **City/ State/ Zip**:_____