PREFERRED PHYSICAL THERAPY

PATIENT INFORMATION – MINOR CHILD

Last Name_____ First Name_____ MI _____ SEX____
DOB ____ / _____ / _____ AGE ____ SSN # _____ - _____ - _____
Address _____
City _____ State ____ Zip Code _____
Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

MOTHER'S INFORMATION

Last Name_____ First Name_____ MI _____ SEX____
Marital Status (circle one) S M D W DOB ___ / ____ / _____ AGE ____ SSN # ____ - ____- ____
Address (if different from patient) _____
City _____ State ____ Zip Code _____
Occupation _____ Employer _____ Work Phone ( ) _____
Employer Address _____
City _____ State ____ Zip Code _____

FATHER'S INFORMATION

Last Name_____ First Name_____ MI _____ SEX____
Marital Status (circle one) S M D W DOB ___ / ____ / _____ AGE ____ SSN # ____ - ____- ____
Address (if different from patient) _____
City _____ State ____ Zip Code _____
Occupation _____ Employer _____ Work Phone ( ) _____
Employer Address _____
City _____ State ____ Zip Code _____

EMERGENCY CONTACT INFORAMTION

Last Name_____ First Name_____ Phone ( ) _____
Address (City/ST/Zip) _____ Relationship _____

INSURANCE INFORMATION (PLEASE PROVIDE COPY OF INSURANCE CARD)

Insurance Co. Name _____ Name of Insured _____
DOB ___ / ____ / _____ SSN # ____ - ____- ____ Relationship to Patient _____
Insured's Employer _____
Policy #_____ Group # _____
Primary Care Physican Name _____ Phone Number ( ) _____

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

_____ _____
Patient Representative (Parent or Guardian) Signature Date