

Everybody Physical Therapy

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ 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 _____

Motor Vehicle Accident _____

That occurred in: _____

Notes: _____

Primary Insurance

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

Secondary Insurance

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

Tertiary Insurance

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

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 forms.

I hereby acknowledge that I have read and do understand the Notice of Privacy Practices and the Patient Information forms. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____