PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE: _____

PATIENT NAME: LAST _____FIRST _____MI _____

ADDRESS: STREET _____ P.O. BOX _____

CITY _____ STATE _____ ZIP _____ PHONE (_____) _____-_____

CELL PHONE (____) _____-_____

SSN#: _____-_____-_____ DATE OF BIRTH: ____/____/____ FEMALE _____ MALE _____ RACE_____

EMAIL ADDRESS_____

STATUS: (CIRCLE ONE) 1. SINGLE 2. MARRIED 3. DIVORCED 4. WIDOWED 5. SEPARATED

GUARANTOR /RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: (_____) _____-_____

EMPLOYMENT INFORMATION

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: STREET _____ WORK FAX # (_____) _____-_____

CITY _____ STATE _____ ZIP _____ WORK PHONE (_____) _____-_____

EMERGENCY CONTACT INFORMATION

NAME: LAST _____ MI _____ FIRST _____

PHONE: (_____) _____-_____ RELATIONSHIP: _____

PHYSICIAN INFORMATION

PRIMARY PHYSICIAN: _____ PHONE: (_____) _____-_____

REFERRING PHYSICIAN: _____ PHONE: (_____) _____-_____

INJURY INFORMATION

DATE OF INJURY: ____/_____/_____ EMPLOYMENT RELATED? YES NO W/C CLAIM? YES NO

HAVE YOU RECEIVED THERAPY/CHIROPRACTIC SERVICES IN THE PAST 12 MONTHS? YES NO

ARE YOU RECEIVING HOME CARE SERVICES? YES NO NAME OF AGENCY: _____

HAVE YOU BEEN A PATIENT HERE BEFORE? YES NO IF NO, HOW DID YOU FIND OUT ABOUT US?

AUTO ACCIDENT? YES NO POST OPERATIVE? YES NO

INSURANCE INFORMATION

PRIMARY: _____ INSURED ID #: **COPY CARD**

S.S.#_____-_____-_____

NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____/_____/_____

INSURED'S EMPLOYER: _____ RELATIONSHIP TO INSURED:_____

SECONDARY: _____ INSURED ID #: **COPY CARD**

NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____/_____/_____

INSURED'S EMPLOYER: _____ RELATIONSHIP TO INSURED:_____

FINANCIAL AGREEMENTS For and in consideration of services rendered or to be rendered to the above named patient by P.T. Services, Rehabilitation Inc. I agree, whether acting as an agent or patient, to pay the amount due this facility. I will make current payments as bills are rendered or I will assign my insurance benefits for direct payment to this facility, and I will pay copay amounts at the time service is provided and any uncovered differences upon receipt of a statement. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____

WITNESS: _____ DATE: _____