REMOBILITY PHYSICAL THERAPY

PATIENT INFORMATION

(Please Print)

DATE: / / NAME: Last: First: MI:

Please give a picture ID and insurance cards to the receptionist for copying.

ADDRESS:

CITY/STATE/ZIP:

MARITAL STATUS: S M W D BIRTH DATE: / /

HOME PHONE: WORK PHONE:

CELL PHONE: EMAIL:

EMPLOYER/SCHOOL:

OCCUPATION:

PHYSICIAN NAME: PHONE #:

SPOUSE/PARENT: PHONE#(If different):

PERSON RESPONSIBLE FOR PAYMENT (If not same as above):

NAME:

RELATIONSHIP: PHONE #:

EMERGENCY CONTACT #1:

RELATIONSHIP: PHONE #:

EMERGENCY CONTACT #2:

RELATIONSHIP: PHONE #:

WORKER'S COMPENSATION: DATE OF INJURY: / /

EMPLOYER CONTACT: PHONE #:

CLAIMS HANDLER: PHONE #:

CLAIM #: SOC. SEC. #:

AUTO ACCIDENT: Please provide auto insurance info (primary) and personal health insurance (secondary). A copy of your police report is required. We do not accept attorney liens or 3rd party insurance. DATE OF ACCIDENT: / /

CLAIM HANDLER: PHONE#:

CLAIMS ADDRESS:

CITY: STATE: ZIP: FAX#:

HOW DID YOU FIND US? (Specify) Search Engine_______ Phone Book __________

Provider Directory ____________________ Advertisement__________________

Doctor____________________ Friend/Family__________________________

Other:

THANK YOU FOR COMPLETING THE ABOVE INFORMATION. ALL PROFESSIONAL SERVICES RENDERED WILL BE CHARGED TO THE PATIENT. PLEASE PLAN TO PAY ALL CO-PAYS AND DEDUCTIBLES AT EACH VISIT. THANK YOU FOR CHOOSING OUR CLINIC. WE PROMISE TO PROTECT YOUR PRIVACY AND PROVIDE YOU WITH COMPETENT, CARING ATTENTION.