HEALTHCARE PHYSICAL THERAPY

Date _____

Office Use Only
First Visit_____
DX_____
Dr._____

Last Name _____ First Name _____ MI ____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Marital Status Single ○ Married ○ Other ○ _____ Gender Male ○ Female ○

Date of Birth _____ Age _____ Spouses Date of Birth _____

Employer _____ Occupation _____

Employment Status Full Time ○ Part-Time ○ Unemployed ○ Student ○ Date Last Worked _____

Social Security # _____ Driver's License # _____

In case of emergency, please contact

Last Name _____ First Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ Relationship to you _____

Referring Doctor _____ Family Doctor _____

Have you had PT from another clinic this year? Yes ○ No ○ If Yes, approximately how many visits? _____

May we leave voice mail or text messages regarding your appointments?

Home Yes ○ No ○ Cell Yes ○ No ○ Work Yes ○ No ○

How did you learn of our practice?

Physician ○ Physician Staff ○ Internet Search ○ Family Member ○ Previously Patient ○ _____

Insurance Company ○ Other ○ _____ If previous patient, how long ago?

Medical/ Health Insurance Information - *Please fill out completely, even if you have filled out the above.*

Primary Insured Patient ○ Spouse ○ Parent ○ Other ○ _____

Primary insurance cardholder's name _____ Date of Birth _____

Last Name _____ First Name _____ MI ____

Street Address _____

City _____ State _____ Zip Code _____

Primary Insurance Company _____ PPO ○ HMO ○ Other ○ _____

Secondary Insurance Company _____ PPO ○ HMO ○ Other ○ _____