

Patient Information

Name _____ Address _____ _____ <small>City State Zip Code</small> Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____ Onset of Symptoms/Injury Date ____/____/____ <small>(Either approximate or specific)</small> Referring Physician _____ Emergency Contact _____ Emergency Contact Phone (____) _____	Date of Birth ____/____/____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Social Security # ____-____-____ Employer _____ Occupation _____ Employer's Address _____ _____ <small>City State Zip Code</small> Spouse _____ Spouse Phone (____) _____
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PRIMARY INSURANCE COMPANY:

SECONDARY INSURANCE COMPANY:

Insurance Company _____ Insured Name _____ Relation to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Sex <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth _____	Insurance Company _____ Insured Name _____ Relation to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other Sex <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth _____
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IF YOU HAVE HAD AN ACCIDENT (Work or Auto), PLEASE COMPLETE THIS SECTION:

Date of Accident _____		How did it happen? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other _____	
Insurance Company (Worker's Comp./Auto Ins) _____			
Address _____		Phone _____	
Claim Number _____	Adjuster _____	Name of Insured _____	

A complete and detailed physical evaluation is one of the most important tests to determine your condition and appropriate treatment. During this evaluation you will be asked to perform maneuvers. We would like you to be as cooperative as possible. However, if you know that a particular maneuver or activity will cause pain or significant injury, please do not attempt to perform that maneuver and let the therapist know at that time. Under no circumstances should you perform or submit to any part of the evaluation which might cause you significant pain.

Assignment of Benefits:

I understand that I am responsible for the payment of all services rendered regardless of insurance payment. I authorize payment of medical benefits to the named provider for professional services rendered.

Release of Information:

I authorize the release of any medical information necessary to process this claim. I authorize the release of information from any medical provider for treatment and billing.

Notice of Privacy Practices:

I acknowledge that I have read and understand the Notice of Privacy Practices of Physical Therapy Partners located in our lobby.

Signed _____ **Date** _____