

Integrated Physical Therapy

PATIENT INFORMATION FORM

Name: _____ Birthdate: _____ Age: _____ M/F

Social Security #: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (H) _____

Email Address _____

Date of Injury/Accident _____ Phone: (Cell) _____

Employer: _____ Occupation: _____ Phone (W) _____

Employer Address _____ HR Phone _____

Reason for visit: _____ Referring Doctor: _____

Primary Doctor: _____ Date of next Doctors appointment: _____

Spouse/Legally Responsible Person _____

Spouse/Legally Responsible Person's Employer _____ Work Phone _____

Emergency Contact: Name: _____ Phone: _____

Are you currently receiving Home Health Care _____ Yes _____ No

How did you hear about our clinic? _____ Doctor _____ IPT Staff _____ Phone Book
_____ Radio _____ Newspaper _____ Other

INSURANCE INFORMATION (Circle One)

Self Pay

Automobile Ins.

Workman's Compensation

Private Insurance

PRIMARY

Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Claim/Group: _____ Policy/ID: _____

SECONDARY (if applicable):

Insurance Company: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Claim/Group: _____ Policy/ID: _____

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