TERRE HAUTE PHYSICAL THERAPY

PATIENT INFORMATION FORM

Please print and complete all information. If any item does not apply, put N/A.

Patient Name:_____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

E-mail:_____

Home Phone: _____ Cell: _____ Work:_____

Date of Birth: _____ Sex:_____ SSN:_____

Spouse/Parent Name: _____ SSN: _____ Date of Birth_____

Referring Physician: _____ Phone Number: _____ Next MD apt. _____

Primary Care Physician: _____ Phone Number: _____

Person to Notify in Case of Emergency:

Name: _____ Home Phone:_____

Work/Cell Phone:_____Relationship:_____

Medical History:

Have you be treated here or by another physical therapist, including home healthcare, in the last 6 months? Yes_____ No_____

If yes, Where?_____ When?_____

Was your treatment for the same condition? Yes_____ No_____ If No, please explain: _____

_____

Onset date of current symptoms/injury/illness: _____

Part of body being treated for this visit: _____

Was this injury related to a work or auto accident? Yes_____ No _____ If Yes, please explain: _____

_____ Date of Accident:_____

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PATIENT INFORMATION FORM

INSURANCE INFORMATION

Who will be primarily responsible for this bill?_____

I will be paying my share of the financial responsibility by: _____

Primary Insurance Company: _____ Phone # _____

Policy Holder:_____ Relationship to patient_____

Policy Holder's SSN:_____ Date of Birth: _____

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I hereby authorize Terre Haute Physical Therapy Inc. to furnish information to my insurance carrier concerning my treatment and assign to the therapist(s) all payment for services rendered. I understand I am responsible for all charges, even those not paid by my insurance. I understand by signing that I am giving my permission for treatment. I also authorize Terre Haute Physical Therapy Inc. to contact the insurance carrier, on my behalf, to assist me in receiving my full insurance benefits. I understand that if my account gets turned over to Capital Accounts my account will then need to be paid directly to the collection agency. You agree, in order for us to service your account or collect any amounts you may owe, we may contact you by telephone at any number associated with your account. This includes wireless phone numbers, text messages or e-mails, which may result in a charge to you. Methods of contact may include using pre-recorded voice messages and/or use of automatic dialing device, as applicable.

*I have read this disclosure and agree that the lender/creditor may contact me as described above.

Signature_____Date: _____

Signature of Parent/Guardian (if patient is under 18 years of age)

How were you referred to our office?

___ Doctor
___Friend/Family – Who may we thank? _____
___ Website/Internet
___Walk-in
___Special Event
___ Other