Patient Information Form

Patient Information			Verified DL/photo i.d:. ☐ Yes ☐ No
Last Name/Suffix	First Name		Middle Initial
Address	City	State	Zip Code
Home Phone	Other Phone (Cell)	Email Address	
Date of Birth	SSN	Sex ☐M ☐F	Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated ☐Unknown

Employer Information			
Employer Name	Employment Status: ☐ None ☐ FT ☐ PT ☐ Self-Emp. ☐ Retired ☐ Student		
Address	City	State	Zip Code:
Work Phone Number	Patient Occupation		

Emergency Contact Information		
Contact Name:	Phone #:	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Sibling ☐ Other

Additional Questions				
Date of Injury Onset Date	Auto Related: ☐ Yes-State?_____ ☐ No **Adjuster name:** _____ **Phone #:**	Work Related: ☐Yes ☐ No	Accident Related: ☐Yes ☐ No	Diagnosis/Body Part

Post Surgical: ☐ Yes / ☐ No /☐ Unknown Surgery Date (if applicable): _____	Surgery Description: _____
Have you any prior Therapy this year? (PT/OT/SP or Chiropractic) ☐Yes ☐No	How did you hear about us?

MEDICARE ONLY- Additional Questions

If Medicare, are you currently receiving Home Health Service? ☐Yes ☐No If yes, Name of Agency ? _____
If Yes, what type of Home Health Services are you receiving?_____Last Date of Service_____

If Medicare, have you received PT, OT or Speech services since the first of the year? ☐ Yes ☐ No

- If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? ☐ Yes ☐ No
- Are you aware of any partial amount used since the first of the year? $_____.
- If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.

Insurance Information

Only complete the following if the Primary or Secondary policy holder is not the patient. Primary ☐ Secondary ☐

Last Name:	First Name:	Middle Initial	SSN	DOB
Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other		Gender: ☐ Male ☐Female		
Employer Name:		Employer Phone #:		
Primary Insurance Section		**Secondary Insurance Section** **Patient Relationship to Policy Holder:** ☐ Self ☐ Spouse ☐ Child ☐ Other		
Payor/Plan	Code:	Payor/Plan	Code:	
Policy/ID #:	Group #:	Policy/ID #:	Group #:	
Insurance Phone #:		Insurance Phone #:		

Patient Signature: _____ **Date:** _____

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