PERFORMANCE PHYSICAL THERAPY

PATIENT INFORMATION FORM

DATE:_____

NAME:_____ D.O.B._____SEX: M( ) F ( )
LAST FIRST M.I.
ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHONE: HOME( )_____CELL: ( )_____EMAIL_____

SS#_____ DRIVERS LICENSE#_____SINGLE ( ) MARRIED( ) DIV( )

_____

WORK INFORMATION

EMPLOYER_____OCCUPATION_____WK PH#_____

ADDRESS:_____

PRIMARY INSURANCE:

INSURANCE CO NAME:_____PH#_____

NAME OF INSURED:_____ID #:_____GRP#_____

DATE OF BIRTH:_____RELATIONSHIP TO INSURED:_____

ANNUAL DED:$_____CO-PAY:$_____

REFERRING DOCTOR:

NAME:_____PHONE #_____

DATE OF INURY/ONSET DATE:_____PRESCRIPTION RECEIVED? ( )YES___( ) NO___

EMERGENCY CONTACT

NAME:_____PHONE #_____

AUTHORIZATION:
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TPO PROCESS MY CLAIMS TO MY INSURANCE COMPANY SHOWN ABOVE. I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DUE ME TO PERFORMANCE PT. I UNDERSTAND THAT PERFORMANCE PT WILL BILL MY INSURANCE AS A COURTESY BUT THAT I AM RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT IF MY INSURANCE DOES NOT COVER THE SERVICES RENDERED TO ME BY PERFORMANCE PT.

SIGNATURE:_____DATE:_____
SIGNATURE OF PATIENT (PARENT OR GAURDIAN OF MINOR)