Physical Therapy Associates™

Name_____Date_____
Last First MI
Date of Birth_____ Sex: ☐ Female ☐ Male ☐ Other_____ Nickname_____

Mailing Address_____
Street City State Zip
Physical Address_____
Street City State Zip
Home Phone ( )_____Work ( )_____Cell( )_____

Contact Preference: ☐ Home ☐ Work ☐ Cell Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

E-mail Address_____ (Please print clearly)
☐ Check this box to opt-out of receiving communications from Physical Therapy Associates

Emergency Contact Name/Relationship_____Phone#_____

Referring Physician:_____ Primary Care Physician_____

Employment Info: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired Employer/School Name_____

Employment Address:_____ Occupation:_____

Area of body needing PT:_____Left☐ Right☐ How did you hear about our clinic?_____

Are you: ☐ Pre-surgical ☐ Post-surgical ☐ Non-surgical

Please check any box that applies: ☐ Pregnant ☐ Cancer ☐ Pacemaker ☐ Medications

INSURANCE INFORMATION – PLEASE GIVE YOUR CARD(S) TO THE FRONT DESK FOR COPYING
Are you aware of your health insurance benefits? ☐ Yes ☐ No

Primary Insurance_____

Subscriber's Name_____Date of Birth_____

Secondary Insurance_____

Subscriber's Name_____Date of Birth_____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION
Date of accident_____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred_____

Claim Number_____ Insurance Company (worker's comp or your auto PIP) _____

Claims Address_____Claims Adjuster_____Phone #_____

→ **I verify that the above information is accurate (Signature)**_____