

Patient Information Form

Today's Date _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, Middle Initial)		Date of Birth / /	Sex M F	Marital Status S M W	
Patient Address					
Street		City	State	Zip	
Home Phone ()		Cell Phone ()			
Name of Employer		FULL-TIME <input type="checkbox"/>	Work Phone ()		
Employer Address		PART-TIME <input type="checkbox"/>	Social Security # (Patient)		
Street					
City State Zip					
Spouse/Parent Name (If patient under 18 yrs old)		Date of Birth		Social Security #	
Spouse/Parent Address				Employer	
Street		City	State	Zip	
Emergency Contact		Phone ()		Relationship	
How did you hear about us? Dr. Referral ___ Newspaper ___ Phone Book ___ TV Ad ___ Welcome Wagon ___ Website/Internet ___ Friend/Family ___ Employee ___ Other ___ (Friend/Family Name)				<u>Print your Email address if you give permission to be added to our email list: (Company News, Discounts, & Promotions)</u>	

INSURANCE INFORMATION

☐ Check box if the (Primary) Patient Insurance info is the same as above. If not, then please fill out the info

Primary Ins Company Name		Address (Street, City, State, Zip)		Phone ()	
Name of Insured:		Relationship	I.D.#	Group #	
Secondary Ins Company Name		Address (Street, City, State, Zip)		Phone ()	
Name of Insured:		Relationship	I.D.#	Group #	
Is your condition work related?		If Yes, are you insured through your work?			
Is your condition the result of an auto accident?		If Yes, on what date did the accident occur?			

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigned directly to Ability Physical Therapy all insurances benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if not paid by insurance. I hereby authorize Ability Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature
(If minor, parent or legal guardian must sign)

Relationship

Date

CONSENT FOR PHYSICAL THERAPY SERVICES

I understand that I have a condition requiring physical therapy evaluation, treatment, and rehabilitation. I do voluntarily consent to such physical therapy services recommended by the physical therapist or their designees. I am aware that the practice of physical therapy is not an exact science. I acknowledge that no guarantees have been made to me as to the result of these services.

Patient Signature
(If minor, parent or legal guardian must sign)

Physical Therapist Signature

Date