



**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ (Jr., Sr., ect.) Sex: M or F  
First Name: \_\_\_\_\_ Middle Initial or Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt./Space: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Divers License #: \_\_\_\_\_ State: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

**PARENT/RESPONSIBLE PARTY FOR PAYMENT:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Date of Follow up Appointment with referring Doctor: \_\_\_\_\_ Part of Body being Treated: \_\_\_\_\_

Your Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

On the Job Injury?  YES  NO X Rays Taken?  YES  NO  Right Handed  Left Handed

Primary Ins: \_\_\_\_\_ Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Worker's Comp. Insurance Co. \_\_\_\_\_ Claim # \_\_\_\_\_

Auto Accident ?  YES  NO Do you have an Attorney pertaining to this injury?  YES  NO

If yes, Attorney's Name: \_\_\_\_\_ Attorney's Phone: \_\_\_\_\_

**NEXT OF KIN INFORMATION**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**PREVIOUS THERAPY INFORMATION**

Have you received any other Therapy Services in this calendar year?  YES  NO

Have you received or are you currently receiving Home Health Therapy?  YES  NO If yes, please provide dates: \_\_\_\_\_

Have you or are you currently receiving Chiropractic treatment?  YES  NO

I hereby authorize payment of medical benefits to MATT SMITH PHYSICAL THERAPY, for services furnished me. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OF NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE IS NOT A GUARANTEE OF PAYMENT.

\_\_\_\_\_  
Patient's Signature or Responsible Party Signature

\_\_\_\_\_  
Date