



Patient Information Form

Patient's Name _____
Please Print First Name Middle Initial Last Name

Address: _____

City: _____ State: _____ Zip: _____ S.S.#: _____

Sex: M / F Date of Birth: _____ Age _____

Home #: (____) _____ Cell #: (____) _____

Employer: _____ Work #: (____) _____

Emergency Contact Name _____

Relation to Patient: _____ Phone#: (____) _____

Date of Injury: ____/____/____ Date of Surgery ____/____/____

Injured Body Part: _____ Left / Right

Referring Physician: _____ Primary Care Physician: _____

General Insurance: HMO/PPO/OTHER _____

Insurance Carrier's Name: _____ Phone #: (____) _____

ID #: _____ Group #: _____

Name of Policy Holder:: _____ DOB: _____

Social Security #: _____ Employer: _____

Sex: M / F Relation to patient: _____

Continued on back page...

Auto/Workers Compensation Claims:

Claim Company: _____

Adjuster: _____ Phone: _____

Fax Number: _____ Claim #: _____

Billing Address: _____

Self Pay Patients: please check here if applicable _____

I _____ am electing to be a self pay patient. I am aware that the fee is \$85.00 required at the time of check-in every visit. I am also aware that any insurance I may have will not be billed by Physio Pro PC and that Physio Pro Pc will have no contact with insurance companies in exchange for this reduced rate. If I decide at a later time to bill through my insurance I understand that Physio Pro PC will then bill normal therapy rates which may be higher than the self pay rate.

By my signature I am verifying that all of the information above is accurate to the best of my knowledge.

Patient Signature and/or Responsible Party

Today's Date

Employee Signature