

Patient Information Form

Date: _____
Married ___ Single ___ Divorced ___ Widowed ___
Male ___ Female ___

PT: _____
Chart #: _____
Ref. Phy: _____

Patient's Name: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security: _____ Date of Birth: _____ Age: _____

Patient's Employer: _____ Phone # _____
Employer's Address: _____
Job Title: _____

Spouse or Parent's Name: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____
Spouse or Parent's Employer: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____

Name, address, and phone # of nearest relative and/or someone who can be notified if we need to get in touch with patient:
Name: _____ Relationship: _____ Phone # _____
Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Policyholder's Name: _____ D.O.B. _____
Secondary Insurance Policy holder's Name: _____ D.O.B. _____

Medicare Insureds: Have you received any physical therapy this calendar year? Yes ___ No ___
Are you currently in a skilled nursing facility? Yes ___ No ___ Do you receive home health services? Yes ___ No ___
If yes to above questions, who provided these services? _____

Injury Information: Work Comp ___ Sports ___ Home ___ Liability ___ Auto ___ State (if auto): ___
Type of Injury: _____ Date of Injury _____
Explanation of Injury: _____

Authorization To Release Information

Authorization For Direct Payment Of Benefits

I hereby authorize Salina Physical Therapy, LC to furnish information to my insurance carrier(s), attorney(s), physician (s), physical therapist(s), and rehabilitation consultant(s) concerning my illness and treatment. I also authorize my insurance carrier(s), attorney(s), physician(s), physical therapist(s) and rehabilitation consultant(s) to release information needed directly to the above named clinic.

I hereby authorize and direct my insurance company to pay directly to Salina Physical Therapy, LC such sums as may be due and owing for services rendered me both by reason of this incident or accident and by reason of any other bills that are due the clinic.

I fully understand that I am directly and fully responsible to said Clinic for all medical bills submitted by it for services rendered me and that I am responsible for any remaining balance after benefits paid.

Signature of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date

Date