Patient Information Form

Today's Date_____

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, Middle Initial)	Date of Birth / /	Sex M F	Martial Status S M W
Patient Address Street City State Zip			
Home Phone ( ) Cell Phone ( )			
Name of Employer	FULL-TIME ☐	Work Phone ( )	
Employer Address Street_____ City_____State_____Zip_____	PART-TIME ☐	Social Security # (Patient) - -	
Spouse/Parent Name (If patient under 18 yrs old)	Date of Birth	Social Security #	
Spouse/Parent Address Street City State Zip		Employer	
Emergency Contact	Phone( )	Relationship	

How did you hear about us? Dr. Referral ___ Newspaper ___ Phone Book ___
TV Ad ___ Location ___ Website/Internet ___ Friend/Family _____
Employee ___ Other _____ (Friend/Family Name)

Print your Email address if you give permission to be added to our email list: (Company News, Discounts, & Promotions)

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 | Relationship | Date

(If minor, parent or legal guardian must sign)

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 | Physical Therapist Signature | Date

(If minor, parent or legal guardian must sign)