Health Plus
PHYSICAL THERAPY CENTER

PATIENT INFORMATION

Last Name: _____ (Jr., Sr.) Sex: M or F

First Name: _____ Middle Initial or Name: _____

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Drivers License #: _____ State: _____

Marital Status: _____

Employer: _____ Occupation: _____

Employer Address: _____

How Did You Hear about Health Plus Physical Therapy?:

Friend/Family (Name)_____ Current/Former Patient (Name) _____ Physician (Name) _____

Internet Search_____ Pass By Office _____

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 herby authorize payment of medical benefits to HEALTH PLUS 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 RESPONSIBILTY 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