EAGLE CENTER PHYSICAL THERAPY
PATIENT INFORMATION SHEET

PATIENT NAME_____ SEX M / F

MAILING ADDRESS_____

CITY/STATE/ZIP _____PHONE_____

SS#_____ BIRTH_____/_____/_____ CELL PHONE_____

EMAIL ADDRESS: _____

PATIENT EMPLOYER_____PHONE_____

CONTACT IN CASE OF EMGERGENCY_____PHONE_____

DATE OF INJURY/SURGERY_____
INJURY/SURGERY WAS: Work related (____) Automobile accident (____) Other_____
REFERRING DOCTOR_____ HOW DID YOU HEAR ABOUT US?_____

SPOUSE OR PARENT INFORMATION

RELATION_____NAME_____SS#_____
MAILING ADDRESS: (*Fill in only if different than Patient Address*) _____
CITY/STATE/ZIP_____PHONE_____

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE CO._____
INSURED: _____ D.O.B_____ ***COPY OF INS CARD ATTACHED***_____
PATIENT/INSURED RELATIONSHIP: _____
(*Fill in only if copy of card not attached* POLICY /ID # _____ GROUP_____)

SECONDARY INSURANCE CO._____
INSURED: _____ D.O.B_____ ***COPY OF INS CARD ATTACHED***_____
PATIENT/INSURED RELATIONSHIP: _____
(*Fill in only if copy of card not attached* POLICY /ID # _____ GROUP_____)

WORKER'S COMPENSATION / AUTO ACCIDENT
EMPLOYER NAME_____PHONE_____
INSURANCE CO._____PHONE_____
ADJUSTOR (CASE WORKER) _____CLAIM NO._____

We are responsible for contacting your insurance company and confirming your physical therapy coverage and any policy limits.

CONSENT FOR TREATMENT

I hereby authorize any physical therapist employed by Eagle Center Physical Therapy to administer care as deemed necessary.
I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account. Returned checks will be charged $25.00 per month and BALANCES OLDER THAN 30 DAYS WILL BE SUBJECT TO ADDITIONAL COLLECTION FEES OF $35.00 PER MONTH. I have read all the information and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
SIGNATURE DATE