ABC PHYSICAL THERAPY
PATIENT INFORMATION

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security no.: Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Home phone no.: ( ) Cell phone no.: ( )

City: State: ZIP Code:

E-mail address:

Referred by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ No Fault ☐ Workers Comp. ☐ Medicare ☐ BC/BS ☐ Empire

☐ CIGNA ☐ UHC ☐ GHI ☐ HIP ☐ Oxford ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SYMPTOMS

Condition to be treated/Symptoms: Previously treated? When? Where?

List all previous treatments for this condition:

List all medications currently being used: