Print Form

team PHYSICAL THERAPY

INDUSTRIAL
Patient Information

Patient Name: _____ Date: _____
Last *First* *Middle Initial*

Home Address: _____
Street *City* *State* *Zip*

e-mail: _____ Date of Birth: _____ Age: _____

Home Phone No.: _____ Cell Phone No.: _____

Social Security No.: _____ Sex: ☐ Female ☐ Male

In Case of Emergency, contact: _____ Phone No.: _____

Relationship to Patient: _____

Employer: _____ Phone No.: _____

Address: _____
Street *City* *State* *Zip*

Occupation: _____ How Long Employed?: _____

Work Hours: _____ Supervisor: _____

Job Description: _____

Industrial Insurance Carrier: _____ Phone No.: _____

Address: _____
Street *City* *State* *Zip*

Adjuster's Name: _____ Adjuster's Phone No.: _____

Claim No.: _____ Date of Injury: _____

Date First Treated: _____ Initial medical care provided by: _____

Physician who referred you to Team Physical Therapy? _____

Physician's Phone No.: _____ Physician's Fax No.: _____

How did the injury occur? _____

Reason for Physical Therapy? _____

Date Last Worked: _____

In your opinion, is this injury related to any previous injury for which you have been treated by Team Physical Therapy? ☐ Yes ☐ No

If yes, please explain: _____

I, hereby give consent for Team Physical Therapy, Inc to contact my employer and/or my employer's industrial insurance company for the purpose of verification of my industrial accident and for authorization of treatment.

I understand that if a determination is made that my injury is not a Worker's Compensation injury, I am personally responsible for payment of all charges incurred. I designate, by my signature that to the best of my knowledge all the preceding information true and complete. My signature gives my consent for treatment by Team Physical Therapy, Inc.

_____ _____
Patient's Signature Date