Print Form

team PHYSICAL THERAPY

NON-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

Employer: _____ Phone No.: _____

Address: _____
Street City State Zip

Occupation: _____

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

Relationship to Patient: _____

Have you been a patient of Team Physical Therapy before? ☐ Yes ☐ No If yes, when? _____

Have other family members received treatment by Team Physical Therapy? ☐ Yes ☐ No

If yes, previous patient's name: _____

Reason for this visit? _____

Who referred you to Team Physical Therapy? _____

Is this condition the result of a motor vehicle accident? ☐ Yes ☐ No

If yes, date of accident: _____ Where did the accident occur? _____

Are you represented by an Attorney for this accident? ☐ Yes ☐ No Name of Attorney: _____
Phone No.: _____

Is this condition the result of an accident at work? ☐ Yes ☐ No

If yes, please explain: _____

FINANCIALLY RESPONSIBLE PARTY/SUBSCRIBER (POLICY HOLDER)

Name: _____ Social Security No.: _____
Last First Middle Initial

Relationship to Patient: _____ Date of Birth (required): _____

Employer: _____ Phone No: _____

Address: _____
Street City State Zip

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Phone No: _____

Policy No./Member ID: _____ Group No.: _____

Secondary Insurance Carrier: _____ Phone No: _____

Policy No./Member ID: _____ Group No.: _____

I, _____ consent to care and treatment, now and in the future by Team Physical Therapy.
Print Name

_____ _____ _____
Patient's Signature Financially Responsible Party's Signature Date