

# Fundamental Physical Therapy

Today's date:				PCP:					
PATIENT INFORMATION									
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home phone no.: (    )		Cell no.: (    )			Birth date: /   /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:			Email address:			
P.O. box:		City:			State:		ZIP Code:		
Occupation:		Employer:				Employer phone no.: (    )			
Referring Physician:					Date of next appt with Physician:				
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 patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Please indicate primary insurance (circle one)		Medicare	BCBS	UHC	Healthchoice	Other:			
Subscriber's name:		Subscriber's S.S. no.:	Birth date: /   /		Group no.:		Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p>				
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>	