

**For official use only:**

Physical Therapist: _____

DX: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female S.S. #: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Physician's Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

If Married: Spouse's Name: _____ Employer: _____

Home Phone: _____ Work Phone: _____ S.S. #: _____

PLEASE COMPLETE IF PATIENT IS A MINOR:**Mother/Guardian's Name:** _____ Address: _____

City: _____ State: _____ Zip Code: _____ S.S. #: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Father/Guardian's Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ S.S. #: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

INSURANCE INFORMATION: Please present the front office with insurance cards**Primary Insurance Carrier's Name:** _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID #: _____ Group #: _____ Date of Birth: _____

Secondary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID #: _____ Group #: _____ Date of Birth: _____

Is treatment a result of a: ☐ On the job injury ☐ Auto ☐ Accidental

Date of Injury: _____ Claim #: _____

Emergency Contact (Not living with you): Name: _____ Phone: _____

I authorize West Richland Physical Therapy to use and disclose health and medical information for the purpose of treatment, payment and health care operations under all circumstances. I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to West Richland Physical Therapy for services rendered. I have received this Practice's Notice of Privacy Practices written in plain language.

Signature _____ Date: _____