MERIDIAN PHYSICAL THERAPY NORTH

For official use only:
Physical Therapist : **DS**____ **BP**____ **MA**___
Diagnostic Code: _____
Insurance_____Visits _____
Physician _____Script ____
Initial Eval: _____Faxed _____

Patient Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:** _____
(P.O. Box)_____ **Work Phone:** _____

City: _____State _____ Zip Code _____ **Email** _____

Date of Birth: _____ ☐ **Male** ☐ **Female** **Social Security #** _____

Referring Physician: _____ **Physician Phone:** _____Fax: _____

Physician Address: _____City _____State _____Zip Code _____

If Married:

Spouse's Name_____Birthdate:_____

Social Security #_____

Employed by: _____

Business Address: _____

City/State/Zip _____Phone: _____

Emergency Information
Relative/Friend-Not Living With You
Name: _____

Relationship: _____Phone: _____

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

Signature: _____

Date: _____

Employer:_____

Employer Phone: _____

Employer Address: _____

City _____ State _____Zip Code _____

Please complete if Patient is a MINOR:

Parent/Guardian Name: _____

Address: _____

City/State/Zip _____

Social Security # _____

Employer: _____

Work Phone _____

Custody: ☐ Joint ☐ Mother ☐ Father ☐ Other

Please provide insurance cards and fill out Insurance, auto or workman's compensation information on other form

Height _____Weight _____
Blood Pressure _____

How did you find out about our clinic?

Dr. Referral ☐ Friend/Colleague ☐ Previous patient ☐

Other: _____