SANTIAM PHYSICAL THERAPY

RETURNING PATIENT?
____Yes ____No

For official use only:
Physical Therapist:_____
Diagnosis Code:_____

Patient's Name: _____ Home Phone:_____

Address: _____ Cell Phone:_____

City: _____ State: _____ Zip Code:_____

Date of Birth: _____ Sex: _____Male _____Female SS#:_____

Employer: _____ Work Phone:_____

Employer Address:_____ City:_____ State:_____ Zip_____

Referring Physician: _____ Phone:_____

Physician's Address:_____ City:_____ State:_____ Zip_____

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

Home Phone: _____ Work Phone: _____ SS#_____

**********PLEASE COMPLETE IF PATIENT IS A MINOR**********

Mother/Guardian's Name: _____ Phone:_____

Address:_____ City:_____ State:_____ Zip_____

SS#:_____ Employer: _____ Phone:_____

Employer Address:_____ City:_____ State:_____ Zip_____

Father/Guardian's Name: _____ Phone:_____

Address:_____ _____ City:_____ State:_____ Zip_____

SS#:_____ Employer: _____ Phone:_____

Employer Address:_____ City:_____ State:_____ Zip_____

*****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#: _____ DOB:_____

Secondary Insurance Carrier's Name: _____ Address:_____

Subscriber's Name:_____ Employer Name:_____

Subscriber's ID#: _____ Group#: _____ DOB:_____

Treatment is a result of: ____On the job injury ____Auto ____Accidental

Date of Injury: _____ Claim #:_____

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

I authorize Santiam Physical Therapy to use and disclose health and medical 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 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 Santiam Physical Therapy for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature: _____ Date:_____