"Providing Excellence in Physical Therapy and Wellness"

Date: _______________

Patient Name____________________________________ **Social Security Number**____________________________

Age___________________ **Sex**: Male Female **Date of Birth**_______________________________________
Address____
City/State/Zip____

Home Phone ________________________________ **Work Phone**_______________________________________
Cell Phone: _________________________________ **Email:**____

Marital Status: Single Married Divorced Separated Widowed **Student Status**: FT PT non-student

Employer____________________________________ **Insured Employee**_________________________________
Address____
City____**State**____________________**Zipcode**____________________

Emergency Contact________________________________**Phone#**____

Referring Physician___________________________**City**____
How did you hear about us? ____
Date of current illness____

RESPONSIBLE PARTY
Name of person responsible for account____
Relationship to the patient: self spouse parent other
Address____
City/State/Zip_____________________________________ Phone #____
Date of Birth_____________________________________ SSN#____

Insurance Information
Insurance Company____________________________________ ID#____
Relationship to the Insured______________________________ Group #_____________________________________
Policy# or Claim#_____________________________________ Phone#______________________________________
Insured Name_______________________________________ Insured Date of Birth___________________________
Date of Injury__________________ Adjustor's Name____
Address ____

Secondary Insurance (or Health Insurance if Accident)
Name______________________________________Phone#____
Policy/Claim#______________________________Group#___________________Group name___________________
Address____

ALL PATIENTS AND RESPONSIBLE PARTIES PLEASE READ AND SIGN
I authorize release of any medical information necessary to process the claim. I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law.

Patients Signature____Date____________________

2787 Jefferson Street, Austell, GA 30168 Phone: 770.739.1177 Fax: 866.552.8286