



**Patient Information**

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: M F  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: M D S W  
Fulltime Part-time Retired Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Spouse/Parent Information** for insurance and legal purposes

Spouse/Parent Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Sex: M F  
Home Phone, if different: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mailing Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Physical Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Spouse/Parent Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Fulltime Part-time Retired Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's Name if not patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Social Security # if not patient: \_\_\_\_\_ Subscriber's Birthdate if not patient: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber's Name if not patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Social Security # if not patient: \_\_\_\_\_ Subscriber's Birthdate if not patient: \_\_\_\_\_

**\*Is this injury Work-related (L & I) or an Auto accident (MVA)?**

Claim #: \_\_\_\_\_ Date of injury \_\_\_\_\_ Date of surgery \_\_\_\_\_  
Claim Manager/Adjuster: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Surgeries or Major Medical Problems in last 5 years \_\_\_\_\_

Medical problems for which you take Medication \_\_\_\_\_

ALLERGIES \_\_\_\_\_

**Previous Physical Therapy? YES NO Where? \_\_\_\_\_ How many visits? \_\_\_\_\_**

**I certify this information is true, accurate, and complete.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian/Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If minor under 18 years of age)

