Central Physical Therapy Patient Information Form

Welcome! Thank you for selecting our practice. All information will be strictly confidential.

PLEASE PRINT LEGIBLY

Patient Information:

Name: First _____ Last_____

Social Security Number: _____ Date of Birth (MM/DD/YYYY) _____

Address: Street _____

City _____ State/County _____ Zip Code_____

Phone: Daytime/Cell _____ Evening _____

Email: _____

If Child, **Parent/Guardian's Name**: _____

How did you hear about Central Physical Therapy? _____

Who referred you to Central Physical Therapy? _____

Physician's Information: Name_____

Physician's Phone_____ Physician's Fax _____

In case of emergency, please provide us with 2 emergency contacts:

Name: First _____ Last_____

Phone: _____ Email: _____

Relationship: _____

Name: First _____ Last_____

Phone: _____ Email: _____

Relationship: _____

Do you require any special assistance? (Parking needs, mobility issues, allergies/sensitivities): Yes_____ No_____

If yes, please specify:_____

_____

Employer: _____ **Occupation:** _____

Address: Street _____

City _____ State/County _____ Zip Code_____

Primary Health Insurance Information: Carrier Name _____

Subscriber's Name: First _____ Last_____

Subscriber's Date of Birth (MM/DD/YYYY) _____

Relationship to the Subscriber_____

Subscriber's Address (if different from patient)**:** Street _____

City _____ State/County _____ Zip Code_____

Phone: _____ Email: _____

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Secondary Health Insurance Information: Carrier Name _____
Subscriber's Name: First _____ Last_____
Subscriber's Date of Birth (MM/DD/YYYY) _____
Relationship to the Subscriber_____
Subscriber's Address (if different from patient)**:** Street _____
City _____ State/County _____ Zip Code_____
Phone: _____ Email: _____
Is this a worker's compensation: Yes_____ No_____ Case #:_____
Is this an automobile accident: Yes_____ No_____ Case #:_____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____
I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to:
Central Physical Therapy *for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.*

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

CONSENT TO TREAT

I hereby authorize the professional staff at ***Central Physical Therapy*** *to examine & treat me for the injury I have been referred here for or referred myself to.*

_____	_____	_____
Patient Name (Printed)	*Signature*	*Date*
_____	_____	_____
Parent/Guardian Name(Printed)	*Signature*	*Date*

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