WILMINGTON PHYSICAL THERAPY PATIENT INFORMATION SHEET

PATIENT:

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP: _____

SS#:_____ HOME PHONE#:_____CELL PHONE #:_____

DOB:_____ AGE:_____ SEX: M / F EMAIL:_____

EMPLOYER:_____WORK PHONE:_____EXT:_____

MARITAL STATUS: M – S – D – W REFERRING PHYSICIAN:_____

MEDICAL PROBLEM:_____DATE YOU SAW YOUR DOCTOR:_____ _____

STUDENT: YES / NO PART TIME / FULL TIME SCHOOL: _____

AUTO ACCIDENT: YES OR NO DATE OF INJURY / ACCIDENT:_____

WORK INJURY: YES OR NO WORKERS COMPENSATION REPORTED: YES OR NO

EMERGENCY CONTACT :_____PHONE #:_____

INSURANCE: PRIMARY_____ SECONDARY_____
INS. PHONE #: _____ INS PHONE #:_____

****IF THE PATIENT IS NOT THE INSURANCE POLICY HOLDER PLEASE FILL OUT THE SECTION BELOW PERTAINING TO THE POLICY HOLDER/GUARDIAN.****

*****POLICY HOLDER–IF PATIENT IS MINOR ALSO NEED PARENT/GUARDIAN INFORMATION**

NAME:_____
(LAST) (FIRST) (MIDDLE)

Address:_____

INSURANCE COMPANY:_____SUBSCRIBER ID:_____GROUP#:_____

EMPLOYER:_____EMPLOYER PHONE #:_____

EMPLOYER ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

SS#:_____ Date of Birth_____

AUTHORIZATION FOR TREATMENT / RELEASE OF INFORMATION

I hereby authorize Wilmington Physical Therapy, Inc. to release all information acquired in the course of my medical treatment or the treatment of my child to the referring physician, insurance carriers, and/or to the health care financing administration and it's agents. I hereby authorize payment of all medical benefits to Wilmington Physical Therapy, Inc. for services received at this office, including Medicare benefits. I have read the financial policy of Wilmington Physical Therapy, Inc., understand it, signed it and accept complete responsibility or full payment of my medical expenses not compensated by my health insurance carrier.

PATIENT / RESPONSIBLE PARTY / GUARDIAN SIGNATURE:

X_____ DATE_____

A photocopy of this authorization and assignment shall be considered as valid as original.