WELCOME TO OUR CLINIC

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____
Date of Birth: _____ SS#:_____ Sex: M F
Address: _____
City: _____ State: ____ Zip: _____
Home Phone: _____ Cell: _____
E-mail: _____
Primary Physician: _____
Referring Physician: _____

Work Status: Retired Regular Duty Light Duty
Employer: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____

Emergency Contact: _____
Phone: _____

Have you had physical therapy before? Y N
Where? _____ When? _____

HEALTH INSURANCE INFORMATION (Please provide a copy of your insurance card(s).)

1. PRIMARY Insurance _____
   ID#:_____

2. SECONDARY Insurance _____
   ID# _____