In Touch Physical Therapy

Your Pain Stops Here

Patient Information

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married / Single / Divorced / Widowed

Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Appointment Reminders: Text Message or Phone Call Monthly Newsletter Sign Up? Yes or No

Email: _____

Primary Physician_____ **Referring Physician**_____

Person responsible for bill or parent (complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-_____-_____

Relationship to Patient: (please check): ( ) self ( ) spouse ( ) parent Date of Birth: _____/_____/_____

Address: _____
(Street) (City/State/Zip)

Emergency Contact

Name: _____ Relationship to patient: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Primary Insurance Information – PLEASE GIVE YOUR CARDS TO FRONT DESK FOR SCANNING

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

Please Flip Over

Secondary Insurance Information

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

IS THIS VISIT DUE TO A JOB RELATED INJURY OR AUTO ACCIDENT? Yes_____ No _____

IF YES PLEASE FILL OUT INFORMATION

Employer Name: _____

Employer Address: _____
(Street) (City/State/Zip)

Name of Insurance: _____ Policy or Claim Number: _____

Contact Person: _____ Contact's Phone Number: _____-_____-_____

Address for Claims: _____

Date of Injury or Accident: _____-_____-_____

I verify that the above information is accurate

Signature: _____ **Date**: _____

Please tell us how you learned of our service or whom we can thank

( ) I was a Former Patient
( ) Health Club/Professional recommendation
( ) Doctor Recommendation
( ) Yellow Page advertisement
( ) TV/Billboard advertisement
( ) Saw you at an Event

( ) Found you on the Internet
( ) Publication/Newspaper advertisement

( ) Former Patient recommendation
( ) Family/Friend/Co-Worker recommendation
( ) Radio advertisement

( ) Clinic Sign
Event: _____

Website: _____
Publication: _____