SPIER Physical Therapy

Patient Data & Insurance Form

Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ Birth Date: _____

St: _____ Zip: _____ Email Address: _____

Social Security #: _____ Sex: M F Marital Status: M S W D

Employer: _____ **Referred by Dr.:** _____

Employer Address: _____ Injury/Illness: _____

City:St:Zip _____ Injury/Illness Onset Date: _____

Employer Tele. #: _____ Was your injury due to an accident? Yes / No

Work Status: FT PT Retired Student Location of Accident: _____

Emergency Contact: _____ **Phone #:** _____

Type of Accident: Auto Work Related Sports Injury Personal Injury Liability

Injury Details: _____

How did you hear about us? Newspaper Radio Other Referred by: _____

If Other, please indicate: _____

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* MEDICARE & MEDICAID PATIENTS: Have you received Physical Therapy anytime this year? Yes No

1) BMI: Height:_____ Weight:_____ **2) Pain Level: 0 - 10 (10 being highest pain) _____**

3) List Medications or attach list:_____

4) Have you had a fall within the last 4 months Yes_____ No_____

Insurance Information

Do you have Medicare? Yes or No

Do you have Medicaid? Yes or No

Name of Insured _____

Relationship to Patient _____ DOB _____

Insurance Company _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes or No If Yes, complete the following:

Name of Insured _____

Relationship to Patient _____ DOB _____

Insurance Company _____

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Authorization and Release

I certify that the information provided is true and correct to the best of my knowledge and belief. I authorize the Physical Therapist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the Physical Therapist's office insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or land line phone numbers provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice.

Signature of Patient/Guarantor Date