



Personal Information

Patient Name: _____
Last First Middle Initial

Date: _____ Home Phone: _____ Date of Birth: _____ Female Male

Mailing Address: _____
City State Zip Code

Parent/Guardian (if under the age of 14): _____

Social Security #: _____ Marital Status: Married Single Widowed Other

Are you employed? No Full-Time Part-Time Retired Other Student? Full-Time Part-Time

Employer: _____ Work Phone: _____

Referring Doctor: _____ Emergency Contact: _____
(a person outside your household)

Relationship to Emergency Contact: _____ Their phone #: _____

This treatment will be covered by: Insurance Patient Other: _____

INSURANCE INFORMATION

Primary Insurance Covering Treatment: _____

Policy or Claim #: _____ Group #: _____

Is the patient the subscriber? Yes No (please give subscriber's information below)

Secondary Insurance Covering Treatment: _____

Policy or Claim #: _____ Group #: _____

Is the patient the subscriber? Yes No (please give subscriber's information below)

Person to bill after insurance: Patient Subscriber Other: _____

If the patient is NOT the subscriber:

Subscriber's Name: _____ Date of Birth: _____ Social Sec. #: _____

Address (if different from patient): _____

Subscriber's Employer: _____ Relationship to Patient: _____

CONDITION / INJURY INFORMATION

Where did this injury happen?

- Work Home
- Auto Accident Recreation
- Other: _____

Date of Injury: _____

What area of your body is affected? _____

What side of your body is affected? _____

PATIENT CONSENT AND RELEASE

- I understand that FamilyCare Physical Therapy is not responsible for any personal belongings I bring to the clinic.
- I understand that I am financially responsible for all charges and services rendered regardless of litigation, insurance reimbursement, or pending claims. I understand that the parent/guardian of a minor will be responsible for payment.
- I authorize FamilyCare Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to FamilyCare Physical Therapy for any benefits available under my insurance plan.
- I hereby consent to treatment by FamilyCare Physical Therapy
- I acknowledge that I have read and understand the cancellation, no-show, and financial policies.

Patient Signature: _____ **Date:** _____
(Parent/Guardian's signature if patient is under 14)