North Lake Physical Therapy

PATIENT INFORMATION

Name:_____ Date:_______________
Last First MI

Mailing Address:_____
Street City State Zip

Home Phone:_____ Cell #:_____ Work #:_____

SS#: _______________ Birth Date: _______________ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Gender Identity: _____ Preferred Pronouns: _____

Primary Care Physician: _____ Referring Physician: _____

Emergency Contact: _____ Relationship: _____

Home Phone:_____ Cell #:_____ Work #:_____

INSURANCE INFORMATION - *PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING*

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

Subscriber: _____ Subscriber: _____

Birth Date: ____/____/____ Group #: Birth Date: ____/____/____ Group #:

ID #: _____ ID #: _____

IF THIS IS A W/C OR MVA CLAIM PLEASE COMPLETE THIS SECTION

Date of Accident:_______________ How did it happen? Auto☐ Work☐ Other☐ State it occurred: ____

Claim Number: _____ Insurance Company (worker's comp or your auto PIP)_____

Address: _____ Claim's Adjuster: _____ Phone #: _____

Employer & Employer address: _____

May we send you text messages for your appointment reminders to the number(s) listed above? Yes ☐ No ☐

May we send you text messages for Marketing Materials, including patient review requests to the number(s) listed above? Yes ☐ No ☐

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

May we send you emails relating to your care with us? Yes ☐ No ☐

By providing your email address, you understand that email communications may NOT be secure , with a risk of unauthorized access to your information.

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICE OR WHOM WE MAY THANK

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ Found you on the **Internet**
☐ **Clinic Sign**
☐ **Health Club/ Professional**
☐ **Social** media
☐ Saw you at an **Event**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (CHECK ALL THAT APPLY)

Leave Detailed Message: ☐ Home ☐ Work ☐ Cell **OR** Leave Call Back Number Only: ☐ Home ☐ Work ☐ Cell

Speak With Someone Regarding Your Account: ☐ Spouse ☐ Other _____

Patient/Patient Representative Signature:_____ **Date:** _______________