North Lake Physical Therapy

PATIENT INFORMATION

Name:_____ Date:_______________
Last First MI

Mailing Address:_____
Street City State Zip

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

SS#: _______________ Birth Date: _______________ Gender: ☐ M ☐ F

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

Email:_____

Employer:_____ Employer's Address:_____

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:_____

Address:_____

Subscriber's Name:_____ Birth Date: _______________

ID Number:_____ Group Number:_____

Secondary Insurance:_____

Address:_____

Subscriber's Name:_____ Birth Date: _______________

ID Number:_____ Group Number:_____

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 #:_____

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
☐ **Newspaper**
☐ **Doctor** recommendation
☐ Found you on the **Internet**
☐ **Clinic Sign**
☐ **Other**_____
☐ **Health Club/ Professional**
☐ **Yellow Page** advertisement
☐ 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:** _______________