ALLIED PHYSICAL THERAPY

PATIENT INFORMATION

FIRST NAME:	**M.I.**	**LAST NAME:**	
DOB:	**SEX: M F**	**SSN:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE:	**CELL PHONE:**	**EMAIL:**	

We will send an automated appointment reminder prior to each appointment. Please select your preferred method for these reminders. By making a selection below, you also authorize Allied Physical Therapy to leave messages.

_____ Text Message _____ Cell Phone Call _____ Home Phone Call

EMPLOYER NAME:	**WORK PHONE:**	**MAY WE LEAVE MESSAGES?**
EMERGENCY CONTACT:	**PHONE NUMBER:**	**RELATIONSHIP:**

IF PATIENT UNDER IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

PARENT/GUARDIAN NAME:	**RELATIONSHIP TO PATIENT:**

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE COMPANY:	**INSURANCE COMPANY:**
SUBSCRIBER NAME: DOB:	**SUBSCRIBER NAME: DOB:**
MEMBER ID #:	**MEMBER ID #:**
RELATIONSHIP TO INSURED:	**RELATIONSHIP TO INSURED:**

AUTO/WORK INJURY CLAIMS ONLY

IS YOUR INJURY RELATED TO A WORKER'S COMPENSATION CASE OR MOTOR VEHICLE ACCIDENT? YES NO
If yes, please indicate which: _____

ADJUSTER NAME:	**PHONE NUMBER:**
CASE NUMBER:	**DATE OF INJURY:**
NAME OF INSURANCE:	

REFERRAL & INJURY INFORMATION

REFERRING PHYSICIAN:	**CLINIC NAME:**

ARE YOU CURRENTLY SEEING ANYONE ELSE FOR PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY? YES NO

HAVE YOU SEEN ANYONE ELSE THIS CALENDAR YEAR FOR PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY? YES NO
If yes, how many visits? _____

HOW DID YOU HEAR ABOUT ALLIED PHYSICAL THERAPY?

- ☐ **Referred by physician**
- ☐ **I'm a former patient**
- ☐ **Referred by former patient**
- ☐ **Online (specify: Google / Facebook / Yelp / Other: _____)**
- ☐ **Other: _____**

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I understand that I am financially responsible for any balance for services.

SIGNATURE: _____ DATE: _____

Printed Name: _____ Relationship to patient: _____