

# Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your health care needs

## Patient Information

Date\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_ Birthdate\_\_\_\_\_ Age\_\_\_\_\_

Name\_\_\_\_\_ Home Phone\_\_\_\_\_

Address\_\_\_\_\_ Cell Phone\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ Sex: M F

Minor Single Married Long Term Partner Divorced Widowed Separated

Employer\_\_\_\_\_ Business Phone\_\_\_\_\_

Business Address\_\_\_\_\_ Occupation\_\_\_\_\_

In case of emergency, who should we contact?\_\_\_\_\_ Phone\_\_\_\_\_

Who should we thank for referring you?\_\_\_\_\_

Can we leave a message at your listed number? NO YES

## Insurance

Primary Insurance Company\_\_\_\_\_

Subscriber ID #\_\_\_\_\_ Group #\_\_\_\_\_

Primary Policy Holder \_\_\_\_\_ Birthdate\_\_\_\_\_

Secondary Insurance (if applicable) \_\_\_\_\_

Subscriber ID #\_\_\_\_\_ Group #\_\_\_\_\_

## Reason for Visit

Please list your primary complaint or symptoms for needing physical therapy:

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