Sunnyside
Physical Therapy & Wellness

_____ _____/_____/_____ M F

PATIENT NAME (Please Print) **BIRTHDATE** **SEX** **Social Security Number**

_____

MAILING ADDRESS **STATE** **ZIP**

_____

PHYSICAL ADDRESS **STATE** **ZIP**

_____ _____ _____

HOME PHONE **CELL PHONE** **EMAIL Address**

Full Time Part Time Student Retired Not Employed _____ _____

EMPLOYEMENT STATUS **YOUR EMPLOYER** **WORK PHONE**

_____ _____ _____ ___ _____

IF MINOR, GARANTOR **ADDRESS** **CITY** **STATE ZIP PHONE**

_____

EMERGENCY CONTACT **RELATIONSHIP** **PHONE** **YOUR EMAIL**

INSURANCE INFORMATION

- ***PLEASE PROVIDE US WITH YOUR INSURANCE CARD(S) AT YOUR FIRST APPOINTMENT.***
- ***IN ORDER TO CONTROL COSTS, WE REQUIRE THAT ALL CO-PAYS AND DEDUCTABLES BE PAID AT EACH VISIT.***
- ***IF THE PATIENT IS A MINOR, THE GUARDIAN WHO IS THE GUARANTOR MUST SIGN THIS FORM.***
- ***PLEASE CALL YOUR INSURANCE COMPANY IF YOU DO NOT UNDERSTAND YOUR PHYSICAL THERAPY BENEFITS.***

1) Yes No Yes No Self Spouse Dependent
DO YOU HAVE PRIMARY INSURACE? SECONDARY INSURANCE RELATIONSHIP TO INSURED

2) IS THIS A WORKERS COMPENSATION CASE? Yes No
PLEASE HAVE YOUR CASE NUMBER, DATE OF INJURY, NAME OF WORKERS COMPENSATION COMPANY, CASE WORKER Name _____ Phone_____

3) IS THIS A MOTOR VEHICLE ACCIDENT? YES NO
PLEASE HAVE YOUR CASE NUMBER, DATE OF INJURY, NAME OF INSURNACE COMPANY, CASE WORKER Name _____ Phone_____ext._____

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
Have you had any Home Health visits for Physical, Occupational, or Speech Therapy? Yes No

If yes, how many visits have you had?_____

I attest that all the information I have given is truthful, to the best of my knowledge, and that I have read, understand and agree to the policies at Allied Physical Therapy.

PATIENT SIGNATURE **_____ DATE_____**
(GUARDIAN IF MINOR)

(GUARDIAN PRINTED NAME) **_____DATE_____**