BIRD PHYSICAL THERAPY

Patient Information

Patient's Name: _____ Patient's Date of Birth: _____
Sex: M or F SSN: _____ Employer: _____ Marital Status: Single Married Widowed
Address: _____ City: _____ State: _____ Zip:_____
Phone #: (home) _____ (work) _____ (cell) _____
Preferred contact method: _____ May messages be left at this #? YES NO Email: _____
Permanent Address (If different from above): _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

Insurance Information:
Insurance Provider: _____ Is the Patient the policy holder? YES NO
If No, Please List primary insured:
Name: _____ Relationship to insured: _____
Date of Birth: _____ Employer: _____ Phone #: _____
Address: _____

Reason for Visit:
Date of Injury (if applicable): _____
___ Job Related ___ Auto Accident ___ Other (please specify): _____

Referring Physician: _____
Primary Care physician: _____

Past Medical History:
Surgeries: _____
Chronic Medical Conditions: _____
Pacemaker or other implanted device: YES NO (if yes please specify): _____
Latex Allergy: YES NO
List any known medications: _____
_____

Have you consulted or retained an attorney in connection with your injury? YES NO
Attorney's Name: _____ Phone #: _____
Address: _____

I have read and understand the policies regarding payment, privacy, consent, and appointment no-shows.

Patient/Guardian Signature: _____ Date: _____