

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () _____ WORK () _____ CELL () _____

EMAIL: _____ PREFERRED WAY TO CONTACT YOU: HOME WORK CELL SEX: MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____ MARRIED SINGLE DIVORCED WIDOWED OTHER

REFERRING PHYSICIAN: _____ PRIMARY CARE/FAMILY PHYSICIAN: _____
HOW DID YOU HEAR ABOUT US: FAMILY FRIEND PHONE BOOK INTERNET DOCTOR OTHER: _____

EMPLOYER: _____ OCCUPATION: _____ EMERGENCY CONTACT & PHONE#: _____
 Full Time Part Time Retired Unemployed Disabled Student

RESPONSIBLE PARTY INFORMATION *IF SELF CHECK HERE AND SKIP TO NEXT SECTION:* **SELF**

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____ RELATIONSHIP TO PATIENT: _____
STREET CITY STATE/ZIP

PHONE: HOME _____ WORK _____ CELL _____ EMPLOYER: _____ SOCIAL SECURITY# _____

INSURANCE INFORMATION ARE YOU AWARE OF YOUR BENEFITS? YES NO

*PRIMARY INSURANCE: _____ INSURED NAME: _____ SEE COPY OF CARD
POLICY#: _____ GROUP#: _____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

(IF NOT THE INSURED, PLEASE COMPLETE THEIR INFORMATION BELOW)

INSURED'S EMPLOYER: _____ DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

*SECONDARY INSURANCE: _____ INSURED NAME: _____ SEE COPY OF CARD
POLICY#: _____ GROUP#: _____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

(IF NOT THE INSURED, PLEASE COMPLETE THEIR INFORMATION BELOW)

INSURED'S EMPLOYER: _____ DATE OF BIRTH: _____ SOCIAL SECURITY#: _____

ACCIDENT INFORMATION: Was this injury the result of an accident? Yes No
 MOTOR VEHICLE ACCIDENT WORK RELATED OTHER DATE OF ACCIDENT/INJURY: ____/____/____
DO YOU COMMUNICATE WITH THE WORKERS COMP CARRIER: YES NO

HIPAA: By signing this form I acknowledge that I have been informed of the HIPAA "Notice of Information Practices" posted in the waiting room from Physical Therapy Center of Ocean Springs and understand it completely. I can request a copy of this form.

CONSENT: By signing this form, I agree and give my consent for Physical Therapy Center of Ocean Springs to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

SIGNATURE DATE PARENT SIGNATURE IF MINOR DATE