AccessRehab
PHYSICAL THERAPY

Date:________

Patient Information

Name: ____ M / F Date of Birth: ___________

(Last) (First) (M.I.) Age: ____

Social Security #: ____-___-_____ Driver's License #: _________________ Married / Single / Other

Home Address: ____

Email: ____________________________ Work Email: ______________________________

Preferred Contact Email: Home / Work Home #: (___)___________ Cell #: (___)____________

Work #: (___)_____________ Preferred Contact #: Home / Cell / Work Text: Yes / No

Occupation: _____________________ Employer : __________________________________

Work Address:____

Emergency Contact: ___________________ Relationship: _________ Phone #: (___)_________

Referring Physician: ____________________________________ Phone #: (___)___________

Previous Therapy & Location: ____ Date: ________

Body Parts Injured: ______________________________________ Date of Injury: __________

Injury due to work: Yes / No Are you covered under an employer of union policy? Yes / No

Injury related to an accident? Yes / No Injury due to auto accident? Yes / No Other: __________

Financial Type (please circle): HMO/IPA PPO/Private Worker's Compensation

Medicare Self-Pay Personal Injury/Auto-Med

Insured Name: ___________________________________ Relationship: _________________

Address of Insured: ____

Date of Birth: ___________ Social Security #: ____-___-_____ Employer: __________________

Primary Health Ins: _____________________ Secondary Health Ins: _____________________

ID#: _____________ Group#: _____________ ID#: _____________ Group#: _____________

Claim#: _____________ Address to send to claim: ____________________________________

Signature: ____ Date: _____________