Core Physical Therapy LLC

Today's Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell #: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Non-binary/third gender

Email: _____ ☐ Prefer to self-describe: _____ ☐ Prefer not to say

Is it okay for us to send you periodic emails at this email address? Y / N Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____ Phone: _____

Relationship: _____

Is it okay for us to contact you at the above home phone number and leave messages to you or your household members regarding your appointments at Core Physical Therapy? Y / N

INSURANCE INFORMATION

Primary Insurance Coverage

Insurance CO: _____

Address: _____ City: _____ State: _____ Zip: _____

If you are the policy holder:

Name: _____

Policy ID #: _____ Group #: _____

Effective Date: _____ Employer: _____

If you are not the policy holder:

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Policy ID #: _____ Group #: _____

Secondary Insurance Coverage

Insurance CO: _____

Address: _____ City: _____ State: _____ Zip: _____

If you are the policy holder:

Name: _____

Policy ID #: _____ Group #: _____

Effective Date: _____ Employer: _____

If you are not the policy holder:

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Policy ID #: _____ Group #: _____

ATTORNEY INFORMATION

☐ Check if not applicable

Law Firm: _____

Attorney's Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

MEDICAL INFORMATION

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Date of Onset/Injury: _____ Dates of Hospitalization: _____

Is this injury: (Check One) ☐ **Work Related** ☐ **Auto Related** ☐ **School Sports** ☐ **Recreational Sports** ☐ **Other**

If work or auto related, please fill out this section:

Auto or Work Related Claim Number: _____

Date of Injury: _____ When was your last date of work? _____

Claims Agent: _____ Phone: _____

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone #: _____

Employer's address: _____

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICES OR WHOM WE CAN THANK.

☐ I was a former patient

☐ Doctor recommendation Name: _____

☐ Health care provider Name: _____

☐ Internet Search: Search Engine: _____ Keywords: _____

☐ ReDirect Guide

☐ Dex Yellow Pages

☐ Former Patient recommendation Name: _____

☐ Family or Friend recommendation Name: _____

☐ Newspaper advertisement _____

☐ Insurance Company Directory _____

☐ OPTA/AAOMT

☐ Web Page

☐ Walk By

☐ I learned about you another way. Please explain. _____

_____