PRECISION SPORTS PHYSICAL THERAPY

Patient Demographic Form

Name: _____ Patient DOB: _____

Parent's Name (if minor): _____ Parent's DOB (if minor): _____

Email: _____ ◯ Male ◯ Female Social Security #: _____

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

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

Emergency Contact Name: _____ Phone #: _____

Body Part/Diagnosis: _____ Referring Physician: _____

Date of Injury: _____ Surgery: ◯ Yes ◯ No Date of Surgery: _____

Prior Treatment for this? _____ When/How long? _____

Referred by: _____

Do you have a Flexible Spending Account or Health Savings Account? **Yes / No**

Insurance Information

Primary Insurance Company: _____ Member ID#: _____

Provider Phone #: _____

Secondary Insurance Company: _____ Member ID#: _____

Provider Phone #: _____

Policy Holder Information

Insured Name: _____ Insured DOB: _____ Relationship to Patient: _____

Insured Occupation: _____

Insured Employer Name & Address: _____

No Fault/Worker's Comp

Claim #: _____ WCB Case #: _____

Case Manager: _____ Phone #: _____ Date of Accident: _____

Insurance Company: _____ Occupation: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____

Patient's Signature: _____ **Date:** _____