PARKSIDE PHYSICAL THERAPY

Date________________ Home Phone (______)____________________Cell Phone(____)____________________________

Name____ SS#______________________________
LAST FIRST MI

Address____ City/State________________________ Zip____________________

Age_____ Birth Date ___________ Employer______________________________ Job Title_______________________

Work Phone _________________ email address ________________________ Work Injury?_______ MVA?__________

Referring Physician___________________________ Primary Physician_______________________________________

Spouse's Name ____________________________

Primary Insurance

Person Responsible for Account____
LAST FIRST MI

Relation to Patient________________ Birthdate______________ SS#___________________ Date of Injury__________

Address (If different from Patient) ____ Phone(___)______________

City____ State___________________ Zip___________________________

Person Responsible Employed by___________________________________Work Phone (____)___________________

Insurance Co.______________________________ Subscriber #________________________ Group #______________

Additional Insurance

Is patient covered by additional insurance? _____Yes ____No

Subscriber Name ___________________________Relation to Patient _______________ Birth Date __________________

Address (If different from Patient)____Phone(___)__________________

City______________________________________ State___________________________ Zip____________________

Insurance Co.________________________________ Subscriber#_______________ Group#______________________

Assignment and Release

I certify that I, and/or my dependent have insurance coverage with________________________ & assign directly to Parkside Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions. Parkside Physical Therapy may use my health care information and may disclose such information to the above-name insurance company(ies) and their agent for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____
Signature of Patient, Parent, Guardian or Personal Rep Date

____ ____
Please Print Name of Patient, Parent Guardian or Rep Relationship to Patient

Whom may we thank for referring you?____

In case of emergency who should be notified?_____________________________ Phone(____)____________________