PATIENT INFORMATION

Name: ____
First Name Middle Name Last Name
911 Address: ____
City: ____________________County of:___________ State: _____ Zip: _________
P. O. Box Address:___________ City:________________ State: _____Zip: ______
Home Phone #: ____________ Work Phone #: _____________
Social Security #: ________________ Sex: _____ Birth Date: _________ Age: ____
Employer Name:__________________ Employer Phone #:________________
Employer Address:____

Marital Status : ❏ Single ❏ Married ❏ Widowed ❏ Separated ❏ Divorced
Employee Status: ❏ Full Time ❏ Part Time ❏ Retired ❏ Unemployed ❏ Disabled
Student Status: ❏ Full Time ❏ Part Time
Emergency contact (not living with you):____________________________________
Relationship : _______________ Home Ph. #: __________ Work Ph. #:__________

GUARANTOR (Guardian of a minor under the age of 18)
Name: ____
First Name Middle Name Last NameName
911 Address: ____
City: _________________________________ State: ________ Zip: ________
Home phone #: _________ Work phone #: _________Social Security : _______________

INSURANCE INFORMATION
Do you have health insurance ? ___ Yes ___No If YES, please complete the following:
Primary Insurance Carrier Information:
Primary Insurance Carrier Name: _______________________________________
Address: ____
Phone #:________________
Group #: ____________________Policy # __________
Policyholder's Name: (if different than Patient)_____________Relationship to policyholder:___________
Policyholder's Address: ____
Policyholder's SS # __________________ Policyholder's Date of Birth:_________________
Policyholder's Home Phone #: __________ Policyholder's Work Phone #:__________________
Policyholder's Plan Name or Employer:____________________________________
Is this a COBRA plan? ____Yes ____No (If yes, when did it start?)__________

Second Insurance Carrier Information:
Second Insurance Carrier Name: ____________________________
Address: ____
Phone #:________________
Group #: ____________________Policy # __________
Policyholder's Name: (if different than Patient)_____________Relationship to policyholder:_________
Policyholder's Address: ____
Policyholder's SS # __________________ Policyholder's Date of Birth:_________________
Policyholder's Home Phone #: __________ Policyholder's Work Phone #:_________________
Policyholder's Plan Name or Employer:____
Is this a COBRA plan? ❏ Yes ❏ No (If yes, when did it start?)______________________________

continued . . .

WORKER'S COMPENSATION INFORMATION

Did you injure yourself at work? ❑ Yes ❑ No
If YES, date of accident: _____________ Time of injury: ________Claim #:______________________
Employer at time of injury: ____
Address: ____
Contact Name: ___________________________ Contact Phone #: ___________________________
Who did you report your injury to: __________________________
Do you have an award from the Virginia Worker's Compensation Commission? ❑ Yes ❑ No

AUTO ACCIDENT/LIABILITY INFORMATION

Is your injury the result of an auto accident?: ❑ Yes ❑ No
Is your injury the result of a fall?: ❑ Yes ❑ No

If YES, insurance information:
Name: ______________________________ Phone #: ________________
Address: ____
Policy #: _________________________________
Date of Accident or Injury: ____________________

ATTORNEY INFORMATION

Attorney Name:____
Address: ____
Phone : __________________________

MEDICAL INFORMATION

What part of the body will you be seen for today: _____________________________________❑ left ❑ rght
Please describe the condition you will be seen for today, if an injury, how it happened:
____
____

Were you seen in the Emergency Room?: ❑ Yes ❑ No If YES, Date: _______________________________
Where ?: ____
Have you had X-rays taken?: ❑ Yes ❑ No
Name of Family Physician: ____
Name of Referring Physician : ____
When did you last see the referring physician for this condition?: __________________
Have you received physical therapy this year?: ❑ Yes ❑ No
If YES, Where?: ____
Have you received, or are you currently receiving Home Health Care?: ❑ Yes ❑ No
If YES, who is providing the service?: ____
When did you last receive their service? ____________________

I hereby certify that all the information is true to the best of my knowledge. I authorize treatment of and understand that I am responsible for any and all fees incurred for physical therapy and I am responsible for any and all collection fees and/or attorney's fees, if this account is turned over for collection to an attorney, whether or not suit is commenced.

Patient's Signature: ____ **Date:** ___________________________
(Guardian, if patient is under 18 years of age)

How did you hear about us? ❑ radio ❑ physician ❑ newspaper ❑ website ❑ other____________________
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Which radio station? ❑ Magic FM ❑ The Game ESPN ❑ WLNI ❑ NPR