



Date: _____

First: _____ M.I.: _____ Last: _____ Age: _____

Date of Birth: _____ Social Security Number: _____ - _____ Sex: M F

Home Address: _____

City: _____ State: _____ Zip: _____ - _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Email Address: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ His/Her Employer: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____

NAME

ADDRESS

PHONE

Date of injury / Date of onset: _____ Is this the result of an accident? Y N

If yes, what type of accident? AUTO / WORK / OTHER: _____

Insurance Information:

Primary Carrier: _____ Secondary Carrier: _____

Insured: _____ Insured: _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

ID#: _____ ID#: _____

Phone: _____ Phone: _____

Assignment / Release / Consent:

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Elite Physical Therapy, LLC 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 insurance. I authorize the use of my signature on all insurance submissions. Elite Physical Therapy, LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this form I give Elite Physical Therapy consent to treat me or my dependent(s)

Signature of Patient, Parent, Guardian

Date