ACT PHYSICAL THERAPY

(Please print form and fill out)

PATIENT INFORMATION

_____ _____ _____

Last name First name Middle initial

Address: _____

_____ _____ _____

City State Zip

Phone: _____ Work: _____ Cell: _____

EMPLOYMENT INFORMATION

Name: _____

Address: _____

_____ _____ _____

City State Zip

Phone: _____ Extension: _____

EMERGENCY CONTACT INFORMATION

_____ _____ _____

Name of contact Relationship to patient Phone

Address: _____

_____ _____ _____

City State Zip

ADDITIONAL PATIENT INFORMATION

Sex: Male _____Female _____ Race: _____ Marital Status: Single_____ Married_____ Other_____

Date of Birth: _____ SS#_____

Referring Physician: _____ Diagnosis: _____

Allergies: _____

Current medications (Please list all even Advil)

_____

_____

_____

CONTINUED ON PAGE 2

Surgical History (Please list all surgeries to date)

_____

_____

_____

Current medical conditions (High Blood Pressure, Diabetes, Cancer etc.)

_____

_____

_____

Did you have an accident or injury: YES NO Date of accident: _____

If yes, please explain:

_____

_____

_____

Is this a work related injury? YES NO

HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____

Insurance Company Address: _____

_____ _____ _____

City State Zip

Policy holder name: _____ Policy holder date of birth: _____

Contract number: _____ Group number: _____

Relationship to policy holder: _____ Effective date: _____

CONTINUED ON PAGE 3

SECONDARY INSURANCE

Name of Insurance Company: _____

Insurance Company address: _____

City: _____ State: _____ Zip: _____

Policy holder name: _____ Policy holder date of birth: _____

WORKERS COMPENSATION INFORMATION (IF APPLICABLE):

Insurance Company Name: _____

Address: _____ _____ _____
City State Zip

Adjuster or Case Manager Name: _____ Phone number: _____

PLEASE SIGN BELOW TO AUTHORIZE INSURANCE BILLING

I authorize that payment by my Insurance Company be made directly to ACT Physical Therapy on my behalf for services furnished to me. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents and any information to determine benefits payable for related services. I further recognize that if the insurance company makes payment directly to me, the amount received is the property of SVO Physical Therapy and its agents to render treatment to me as deemed appropriate and as prescribed by my physician.

SIGNATURE: _____ **DATE:** _____