PATIENT INFORMATION

Last name:_____ LEGAL First name: _____ MI: ____
Preferred name (if different): _____ Preferred pronouns (if any): _____
Date of birth: _____/_____/_____ Age: _____ Birth sex: M / F
Social Security # (for insurance purposes): _____
Mailing address: _____
City: _____ State: _____ Zip code: _____
Cell phone: _____ Home phone: _____
Email: _____
Employer: _____
Job title: _____ Work phone: _____

Marital status:	Work status:	Student status:
__Single	__Employed	__Full time
__Married	__Retired	__Part time
	__Student	

My condition is located: (body part/s) _____What side: L/R
My condition is related to (select all that apply):

__Auto accident (state:___)	__Another party responsible	__Surgery
__Fall	__Employment injury	__Other accident
__Abuse	__Sports injury	__Age
		__Other: _____

*Regardless whether your insurance is on file, this information **must** be filled out.*

***PRIMARY* INSURANCE** - please fill out

Name of insurance: _____
Policyholder name: _____
Check box if patient is the policyholder and skip to the other side of the page: ☐
Policyholder birth sex: M / F Relationship to patient: _____
Policyholder birthdate: _____
Street address: _____
City: _____ State: ____ Zip code: _____
Cell phone: _____ Home number: _____
Policy holder's SSN: _____

Continued on other side

***SECONDARY* INSURANCE** - please fill out if applicable

Name of insurance: _____

Policyholder name: _____

Check box if patient is the policyholder and skip to the emergency contact: ☐

Policyholder birth sex: M / F Relationship to patient: _____

Policyholder birthdate: _____

Street address: _____

City: _____ State: ____ Zip code: _____

Cell phone: _____ Home number: _____

Policy holder's SSN: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Phone: _____

Which doctor referred you to our office? (Who is treating you for your condition?)

Name: _____ City/State: _____

Consent for Care & Treatment:

By signing below, you agree that:

1. I authorize release of information requested by my insurance plan for payment.
2. I understand I am responsible for any balance due (collection fees of 50% will be added for accounts past due).
3. I agree and give consent to H2 Physical Therapy to furnish medical care and treatment that is considered necessary and proper in diagnosing/treating my (his/her) physical and mental condition.

Patient Signature: _____ Date: _____

or

Parent/Guardian Signature: _____ Date: _____