

Northern Physical Therapy, PC

1. Personal Information.

Name _____ Date of Birth _____

Mailing Address _____

Town _____ State _____ Zip _____

Residential Address _____

Town _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Cell Phone _____ School Telephone _____

Primary Care Physician _____ Referring Physician _____

Social Security Number _____ Male _____ Female _____

Emergency Contact _____ Telephone _____

E-Mail address: _____ Can we contact you by e-mail? Yes or No

2. Important Information.

1. Is your diagnosis related to: A work injury Y N Date of Injury: _____
(Please circle Y or N) A motor vehicle accident Y N
A liability claim Y N

3. Insurance Information.

Primary Insurance:

Name of Insurance _____ (Please provide insurance card)

Name of Subscriber _____ (Person holding policy)

Self ___ Spouse ___ Parent ___ Other ___ Subscriber's Date of Birth ___/___/___

Secondary Insurance (if applicable):

Name of Insurance _____ (Please provide insurance card)

Name of Subscriber _____ (Person holding policy)

Self ___ Spouse ___ Parent ___ Other ___ Subscriber's Date of Birth ___/___/___

4. Payment Authorization.

Payment of medical benefits may be made on my behalf to Northern Physical Therapy, PC for any services furnished to me by the provider. I understand that in accepting medical services, I am also accepting responsibility for payment. I also authorize the medical release of information to my insurance company, as stated in my policy. I also authorize the medical release of medical information to any other medical professional when appropriate.

Signature: _____

Date: _____

How did you hear about Northern Physical Therapy?

Doctor _____ Friend _____ Newspaper Ad _____ other _____