PATIENT INFORMATION SHEET

PATIENT: (Please provide your legal name as it appears on your insurance card)

Last Name: ______________________________________First Name: _________________________Middle:________

Home Address: ____ Apt #_____________________

City: ____ State: _________________ Zip:_________________

Mailing Address: ____ Apt #_____________________

City: ____ State: _________________ Zip:_________________

Home Phone #: ___________________Cell Phone#__________________ Work Phone #:________________Ext______

Date of Birth: ___ / ___ / ___ Age: ______ SS#: __________-______-______________ Gender: M F Martial Status: M S D W

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill.

RP Last Name: _________________________________ First Name: ______________________ Middle: _____________

Home Address: ____ Relationship to Patient_____________________

City: ____ State: _________________ Zip: ________________

Home Phone #: ___________________Cell Phone#__________________ Work Phone #:________________Ext______

Date of Birth: ___ / ___ / ___ Age: ______ SS#: __________-______-______________ Gender: M F Martial Status: M S D W

SPOUSE or GUARDIAN:

Last Name: ___________________________________ First Name: ____________________ Middle:_______________

Employer Name: __________________________________ Work Phone #:____________________________________

Date of Birth: ___ / ___ / ___ SS #: ________________________________Employer:_____________________________

INSURANCE: (please list insurance name and provide a copy of your card to the receptionist)

1st Insurance Company: _________________________________Phone#____

Insured's Name: ______________________________ ID/Policy #:_____________________________Group#____________

Date of Birth: ___ / ___ / ___ Age: ______ SS#: __________-______-______________ Gender: M F Martial Status: M S D W

If Medicaid: Which Doctor is your Passport Provider? ____

2nd Insurance Company

Insured's Name: ______________________________ID/Policy #:_____________________________Group#____________

Date of Birth: ___ / ___ / ___ Age: ______ SS#: __________-______-______________ Gender: M F Martial Status: M S D W

****If Workers Compensation or Motor Vehicle Accident or Personal Injury please complete the attached form****

How did you hear about our clinic?

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Authorization[Form 001]

I hereby assign, transfer and set over to Hamilton Physical Therapy & Sports Rehabilitation Center, P.C. and or its individual Therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X ____Date________________________

Form 001