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?

_____

Authorization[Form 001]

I hereby assign, transfer and set over to Frenchtown Physical Therapy 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_____