Welcome to SHAFFO PHYSICAL THERAPY

New Patient Information

Date: _____

Patient: _____ DOB: _____

Parent/Guardian (if under 18 years of age): _____

Address: _____

_____

Phone: _____ Alt. Phone : _____
Employer: _____ Phone: _____
Employer's Address: _____

_____

Primary Insurance: _____
ID Number: _____ **Group Number:**_____
Secondary Insurance: _____
ID Number: _____ **Group Number:** _____

Subscriber Name: _____
DOB: _____ Phone: _____
Address (if different from patient): _____

_____
Subscriber Employer: _____
Subscriber Address: _____

Condition Related to: Employment _____ Automobile (List State if Auto Related) _____
Other (Please provide detailed information) _____

_____
Onset of Current Illness/Symptom: _____
If unable to work, from _____ to _____.
Hospitalization related to current service from _____ to _____.
Referring Doctor: _____ Phone: _____

I hereby agree to be responsible for the payment of treatment to be rendered to me if the above named person is a minor or dependent. I agree to be responsible for his/her payment. I give informed consent to SHAFFO PHYSICAL THERAPY for treatment and authorize the release of any or all pertinent information regarding my physical therapy to my doctor and my insurance company. I authorize my insurance company to make payment of medical benefits to SHAFFO PHYSICAL THERAPY for services and/or treatments rendered to me. I have read, understood and agreed to the treatment and payment policies explained to me on my first visit.

SIGNATURE_____ DATE_____
(Patient or Guardian)