

ASR PATIENT INFORMATION: SCRIPT DATE _____ ACCOUNT # _____

Patient Name _____ Social Security Number _____

Address _____ City/State/Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Age _____ Sex: M _____ F _____ Marital Status _____

E-mail Address _____ (for patient newsletters – we safeguard your information)

Spouse Name _____ Work Phone _____ Cell Phone _____

PATIENT'S EMPLOYER: _____ Occupation: _____

Address: _____ City/State/Zip Code _____

EMERGENCY CONTACT: Name: _____

Phone: _____ **Relationship:** _____

Referring Physician: _____ Primary Care Physician: _____

Reason for today's visit: _____ Have you ever received therapy for this diagnosis before? Yes / No

Have you had physical therapy or chiropractic care in the past year? Yes / No If so, When? _____

PLEASE PROVIDE INSURANCE INFORMATION: Please fill in or check all that apply

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

Phone Number _____ Phone Number _____

ID or Claim Number _____ ID or Claim Number _____

Worker's Comp _____ Date of Injury _____ Motor Vehicle Accident _____ Date of Loss _____

ARE YOU THE CARDHOLDER? Yes / No If not, please provide the following information:

_____ **Cardholder's Name** _____ **Birth Date** _____

_____ **Employer** _____ **Address** _____ **Work Phone** _____

RESPONSIBLE PERSON'S NAME, ADDRESS & PHONE NUMBER FOR PATIENTS UNDER 18:

Name/Relationship _____ Social Security Number _____

Address _____ City/State/Zip Code _____

Date of Birth _____ Home Phone: _____ Cell Number: _____

CONSENT & RELEASE FOR TREATMENT: I hereby authorize the physical therapist or their assistant to render treatment and procedures in my care. I certify that answers given herein are true and complete, to the best of my knowledge.

Patient (or Guardian) Signature _____ Date _____

VERIFICATION: (Office Use Only)

Insurance Company: _____ Phone: _____

Name of Insurance Service Rep: _____ Date: _____ Time: _____

ID Number: _____ Group Number: _____

Effective Date: _____

Deductible: \$ _____ Met: \$ _____ Co-Pay: \$ _____ Co-Ins: _____ %

Benefit: _____

Authorization #: _____ Number of Visits: _____

Any Special Information: _____

VERIFICATION: (Office Use Only)

Insurance Company: _____ Phone: _____

Name of Insurance Service Rep: _____ Date: _____ Time: _____

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Effective Date: _____

Deductible: \$ _____ Met: \$ _____ Co-Pay: \$ _____ Co-Ins: _____ %

Benefit: _____

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Any Special Information: _____
