

Personal Information

Patient's Name: _____ Date: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Social Security Number: _____ Marital Status: _____ Date of Birth: _____
E-Mail Address: _____ (E-mail is to be used for communication with Parry PT only)

Emergency Information

Person to Contact in the Event of an Emergency: _____ Phone Number: _____

Employment Information

Place of Employment: _____ How Long: _____
Occupational Title: _____
Are you currently working? _____ If no, date last worked: _____
Employer Address: _____

Physician Information

Name of Referring Physician: _____
Name of Primary Care/General Physician: _____ Phone Number: _____

Insurance Information

Name of Insurance Company / Workers Compensation Carrier: _____
Address: _____
Name of Insured as Shown on Policy: _____
Policy #: _____ Claim #: _____ ID #: _____ Group #: _____

Attorney Information

Have you retained an attorney with regard to the above injury? _____
Attorney's Name: _____ Phone Number: _____
Attorney's Address: _____

I hereby authorize Parry Physical Therapy & Athletic Enhancement to bill my insurance company on my behalf, and I direct that payment for treatment rendered be provided directly to Parry Physical Therapy & Athletic Enhancement. I understand that there is no contract between Parry Physical Therapy & Athletic Enhancement and any insurance company or attorney and that I am solely responsible for the payment of any charges incurred at this facility. I understand that charges for services provided are due and payable upon receipt of an itemized bill.

Patient's Signature: _____ Date: _____
(or signature of Parent or Guardian if Patient is a minor)