2020 Patient Information

Referred By: _____ Primary Care Provider:_____

Patient Full Name:_____ Mailing Address:_____

City:_____ State: _____ Zip: _____

Social Security #: _____ DOB:_____ Age: _____

Primary Phone: _____ ○ ○ ◉ home/work/mobile

Secondary Phone: _____ ◉ ○ ○ home/work/mobile

Email: _____Employer: _____

Emergency Contact/Spouse Name and Number: _____

***Responsible Party: _____ Social Security#: _____**

DOB: _____ Employer: _____ Employer#: _____

Primary Insurance: _____ ID#:_____ Group #:_____

Policy holder name: _____DOB:_____ Relation to patient: _____

Secondary Insurance: _____ID#:_____Group #:_____

Is this a Worker's Comp? _____ Company and Claim No.:_____

Reason for Today's Visit: _____

Height: _____Weight: _____

Current Pain Level (0 lowest-10 highest) _____

If Injury, Date of injury: _____ If Surgery, Date of Surgery: _____

Previous Major Surgeries, with date/year: _____

Major Medical Issues (Heart Disease, Diabetes, etc.):_____

- ✓ **I hereby authorize payment directly to Total Physical Therapy and/or medical services under the provisions of my insurance**
- ✓ **I understand that I am financially responsible for charges not covered by my insurance plan and that payment is expected at the time of service for any co-payments and/or insurance exclusion.**
- ✓ **I herby consent to treatment by Hal Schmidt PT and Heather Lien, DPT, Deb Ruehle, MPT**
- ✓ **I authorize release of any medical information necessary for medical care of insurance processing.**

Signature: _____ Date: _____