

**PATIENT INFORMATION**

**Today's Date:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Address OR Phone #** \_\_\_\_\_

**If Self – Referred, how did you hear about us ?** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **What are we treating you for? Please explain:**

**Email Address** \_\_\_\_\_

**Phone #:** (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

**Have you had any Therapy in the last year?** **Was this an accident?** \_\_\_ (y/n) **Date** \_\_\_\_\_

**No ( ) Yes ( ) Type: PT( ) OT( ) Speech ( ) Auto( ) Work Comp ( ) Other? ( )**

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**Employer:** \_\_\_\_\_ **Emergency Contact:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Phone #s:** \_\_\_\_\_

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**Primary Insurance Company:** \_\_\_\_\_ (we need a copy of the insurance card on file)

**Primary Cardholder's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Supplemental Insurance Company:** \_\_\_\_\_ (we need a copy of the insurance card on file)

**Primary Card Holder's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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- I hereby authorize and assign payment of medical benefits to Performance Physical Therapy & Rehabilitation, P.C., for their services.
- I accept financial responsibility for the costs of these services.
- I authorize Performance Physical Therapy & Rehabilitation, P.C., to release to MY insurance company or to MY doctor or ANY healthcare professional involved in my care, any information they may request concerning my present condition or treatment.
- I authorize Performance Physical Therapy & Rehabilitation, P.C., to evaluate and treat my condition with standard physical therapy procedures under the care of my therapist. ( I am aware that I have access to my clinic records upon request.)

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_