Name: _____

Home Phone: _____

Address: _____

_____

Email: _____

Diagnosis: _____

Date of Birth: _____

Emergency phone: _____

Referring physician: _____

Therapist: Jill Boorman (JB) or Patrick Colpitt(PC)

Primary: _____

Insurance Address: _____

_____

Insurance Fax: _____

Subscriber ID: _____

The above explanation of benefits is NOT a guarantee of payment. Insurance benefits are subject to change; it is the patient's responsibility to keep informed on their insurance coverage.

_____ I understand my financial responsibilities. (please initial)

How did you hear about our clinic? _____

EMAIL:_____

Check all that apply:

□ I would like to receive the monthly Premier Physical Therapy newsletter

□ I allow Premier to use my image and feedback on the Facebook page and website

□ I would like to be patient of the month

Is this for an automobile accident? Y or N

If so, in what state did the accident occur? _____

SOCIAL SECURITY NUMBER: _____

Employer:_____Occupation:_____

Phone Number:_____

SPOUSE OR RESPONSIBLE PARENT:

Name: _____ Relationship:_____SS#:_____

Address:_____ City:_____State:____ Zip:_____

Home Phone: _____ Cell Phone:_____

Work Phone:_____ Employer:_____

Notify In Emergency:

Name/ Relationship to Patient:_____

Contact Phone Number:_____

Patient Signature:_____ Date:_____

By signing I verify that the above information is correct to the best of my knowledge.