TOTAL BODY physical therapy
EXPERTS IN MOTION

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Albert Bednar, DPT • Amy Jones, DPT

PATIENT INFORMATION RECORD

PATIENT INFORMATION

Patient Name ______________________________ Age_______ ❑ Male ❑ Female
Last First Middle Initial

Date of Birth: ________/_______/_______Social Security Number ______-______-______Marital Status: S M W D Sep

Mailing Address __________________ City __________ State ________ Zip Code __________

Daytime Phone Number (___)______________ Cell Phone (___)______________ Work phone (___)______________

Email address (PRINT) ______________PRINT (again) ______________How did you hear about us? ______________

Employer ______________________Occupation______________________

Street Address ______________City ____________ State _______ Zip Code __________ Phone (____)________

Patient's Referring Doctor ______________________________ Phone (____)______________

Patient's Primary Care Doctor ______________________________ Phone (____)______________

Office Location: Street Address ______________ City ____________ State _______ Zip _________

ADDITIONAL INFORMATION

Spouse (parent, if minor) ______________________________
Last First Middle Initial

Date of Birth: ________/_______/________ Social Security Number ______-______-______ Phone (____) ______________

Street Address __________________ City ______________ State _________ Zip Code __________

Employer ______________________ Occupation______________ How Long? __________

Street Address ______________City ____________ State ________ Zip Code _________Phone (____)________

Name of Nearest Relative Not Living With You ______________Relationship ______________

Street Address ______________ City ____________State ______ Zip Code _________Phone (____)______________

INSURANCE INFORMATION

Primary Insurance Company ______________________ Is this a work-related injury? (Circle one) Yes No

ID# ______________ Policy # ______________ Group # ______________

Policy Holder's Name ______________ Date of Birth _____/____/_____ Relationship to Patient ______________

Policy Holder's Address (if other than patient's) ______________ City ____________ State _______Zip ________

Policy Holder's Employer Address ______________City ______________State _______ Zip Code________

Secondary Insurance Company ______________________________

ID# ______________ Policy # ______________ Group # ______________

Policy Holder's Name ______________ Relationship to Patient ______________ Date of Birth _____/_____/_____

Policy Holder's Address (if other than patient's) ______________ City ____________ State ______Zip _______

Policy Holder's Employer Address ______________City ____________State ________ Zip Code_______

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for an additional $50 fee. I have read and understand this form.

X______________________________ Date________________

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