

General Information

Name: _____ Sex: _____ Male _____ Female
(first, middle initial, last)

Address: _____ City: _____
State: _____ Zip: _____

SS# _____ - _____ - _____ DOB: _____
Home/Contact Phone#: (____) - _____ - _____ Cell Phone#: (____) - _____ - _____

Diagnosis: _____ Date of Injury: _____

Surgery (related to diagnosis), if any ----Type and Date: _____

Additional Information

Referring Physician: _____ Family Physician: _____
Patient Employer: _____ Employer #: _____

If there is **no** employer, check below:
_____ Student _____ Disabled _____ Retired _____ Unemployed

*****Since January 1, of this year have you had any... Auto Related? YES or NO**
 PHYSICAL THERAPY YES or NO **WC Related? YES or No**
 OCCUPATIONAL THERAPY YES or NO
 SPEECH THERAPY YES or NO
 CHIROPRACTIC CARE YES or NO

If you answered yes to any on the above questions, please mark how many where used. _____
*****THESE THERAPIES MAY COUNT TOWARDS YOUR AUTHORIZATION OR VISIT LIMIT.**

How did you hear about Big Spring PT?

- Dr. _____
- Advertisement/Yellow Pages
- Friend
- Other _____

HIPPA: Other that what is mentioned on the
 Patient Consent Form, please list any
 names you give us permission to release
 or disclose health information:

Emergency Contact Name and Phone#

(in case something were to happen to you here)

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____ Third Insurance: _____

POLICY HOLDER INFORMATION

Is for this 1st, 2nd, 3rd, Insurance

Name: _____ Address (if different): _____
 Phone#: (____) - _____ - _____ DOB: _____ / _____ / _____
 Employer: _____ Relation to the patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Big Spring PT / Shippensburg Physical Therapy and Sports Medicine to release any information required to process my claims.

Patient / Guardian Signature: _____ Date: _____