WEST RICHLAND PHYSICAL THERAPY

For official use only:
Physical Therapist:_____

DX:_____

Patient's Name:_____ Home Phone:_____

Address:_____ Cell Phone #:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Sex: ☐ Male ☐ Female S.S. #:_____

Employer:_____Work Phone:_____

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

Referring Physician:_____ Physician's Address:_____

City:_____ State: _____ Zip:_____ Phone #:_____

If Married: Spouse's Name: _____ Employer: _____

Home Phone:_____ Work Phone_____ S.S. #:_____

PLEASE COMPLETE IF PATIENT IS A MINOR:

Mother/Guardian's Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ S.S. #:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

Father/Guardian's Name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ S.S. #:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

INSURANCE INFORMATION: **Please present the front office with insurance cards**

Primary Insurance Carrier's Name:_____ Address:_____

Subscriber's Name: _____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

Secondary Insurance Carrier's Name:_____ Address:_____

Subscriber's Name: _____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

Is treatment a result of a: ☐ On the job injury ☐ Auto ☐ Accidental

Date of Injury:_____ Claim #:_____

Emergency Contact (Not living with you): Name:_____ Phone:_____

I authorize West Richland Physical Therapy to use and disclose health and medical information for the purpose of treatment, payment and health care operations under all circumstances. I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to West Richland Physical Therapy for services rendered. I have received this Practice's Notice of Privacy Practices written in plain language.

Signature_____ Date:_____