

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

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

S.S. # _____ - _____ - _____ **D.O.B.** _____

Home/Contact Phone: (____) - _____ - _____ **Cell Phone:** (____) - _____ - _____

Diagnosis: _____ **Date of Onset/ Injury:** _____

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

Additional Information:

Referring Physician: _____ **Family Physician:** _____
Patient's Employer: _____ **Employer Phone:** _____

If NO employer, check below:

Student, Disabled, Retired, Unemployed

****Since January 1, 2009 have you had any....**

PHYSICAL THERAPY? NO or YES*
OCCUPATIONAL THERAPY? NO or YES*
SPEECH THERAPY? NO or YES*
CHIROPRACTIC CARE? NO or YES*

Auto Related? Yes or No

WC Related: Yes or No

If WC, employer's name _____

***ANY OF THESE THERAPIES MAY COUNT TOWARDS YOUR AUTHORIZATION OR VISIT LIMIT**

*** If YES to any above. How many visits?** _____

How did you here about Shippensburg PT?

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

HIPPA: Other than 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 this for 1st, 2nd or 3rd Insurance?

Name: _____ **Address (if different):** _____
Phone: (____) - _____ - _____ **D.O.B.** ____/____/____
Employer: _____ **Relationship to 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 Shippensburg Physical Therapy & Sports Medicine to release any information required to process my claims.

Patient/Guardian Signature: _____ *Date:* _____