

Patient Information



Patient Name _____ Male Female
 Married Divorced Widowed Single

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ S.S. Number _____

DOB _____ Age _____ Primary Insured's DOB _____

Employer _____ Employer Phone _____

Occupation _____ Email _____

Date of Injury _____ Date of Surgery _____

How did you hear about us? (check all that apply)

Physician directed me Physician let me choose Family/friend Website
 Location/drove by Former patient here Facebook/Twitter Postcard

Phonebook ad (please list which book) _____

Other (please explain) _____

Referring Physician's Name _____

Is there another physician you would like us to keep updated? _____

Insurance Information

I hereby consent to such physical therapy and occupational therapy procedures as may be rendered by Idaho Physical Therapy. There is also consent for authorization for all insurance benefits to be paid directly to Idaho Physical Therapy and assumption of all financial responsibility for the balance of charges not included in the insurance coverage.

Patient Signature _____ Date _____

Parent Signature (if Patient is under 18) _____

Medicare and Medicaid Patient Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Idaho Physical Therapy for any service furnished me by Idaho Physical Therapy. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services, formally the Health Care Financing Administration, and its agents any information needed to determine the benefits or the benefits payable for related services.

Patient Signature _____ Date _____