



RETURNING PATIENT?

Yes No

For official use only:

Physical Therapist: _____

Diagnosis Code: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: Male Female SS#: _____

Employer: _____ Work Phone: _____

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

Referring Physician: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____ Zip _____

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

Home Phone: _____ Work Phone: _____ SS# _____

*****PLEASE COMPLETE IF PATIENT IS A MINOR*****

Mother/Guardian's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip _____

SS#: _____ Employer: _____ Phone: _____

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

Father/Guardian's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip _____

SS#: _____ Employer: _____ Phone: _____

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

*****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#: _____ DOB: _____

Secondary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID#: _____ Group#: _____ DOB: _____

Treatment is a result of: On the job injury Auto Accidental

Date of Injury: _____ Claim #: _____

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

I authorize Santiam Physical Therapy to use and disclose health and medical information for the purposes 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 Santiam Physical Therapy for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature: _____ Date: _____