S.M.A.R.T.
Physical Therapy

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

Patient Information

Patient's Name ____ Social Security # ____________________

Billing Address ____

City _______________________________________ State _____________ Zip Code _________________

Date of Birth _____/____/______ Age ________ Sex: ☐ M ☐ F Marital Status ______________________

Home Phone ________________ Work Phone ___________________ Cell Phone __________________

Employer's Name _______________________________ Occupation ______________________________

How did you hear about us? ____________________________ E-mail address ______________________

Reason for Visit

Description of Injury _____________________________________Date of Onset / Injury ____/_____/_____

Condition Relates to: ☐Employment ☐Auto Accident (State) _____ ☐Other ______________________

Referring Physician ____ Prescription Date ____/_____/_____

Primary Care Physician (if different from referring physician) ______________________________________

Health Insurance Coverage

Primary _________________Subscriber's Name _______________________ Date of Birth ___/____/____

Secondary _________________Subscriber's Name______________________ Date of Birth ___/____/____

Insurance Member ID #________________________ Provider Services Ph # back of card__________________

Who may we contact in case of an emergency? ____

Home Phone ______________ Work Phone ______________ Relationship to Patient _________________

You are responsible for the payment of charges not covered by your health benefit plan at the time of service. As a courtesy, we will submit your primary insurance claims (on your behalf) if the insurance information provided is correct and complete.

________________________________ ____________________________
Signature of Patient or Legal Guardian Date

________________________________ ____________________________
Relationship to Patient (if applicable Name of Legal Guardian (if applicable)