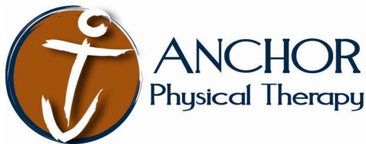

Confidential Patient Information

1407 East 72nd Street
Suite A-100
Tacoma, WA 98404
Phone: (253) 474-7474
Fax: (253) 474-7479

Name ______________________ DOB __ - __ - __ Age ____

Address ______________________ Apt ____ Phone __ - __ - __

City ______________ State ____ Zip ____ Gender ☐ Male ☐ Female

Permanent Address ______________________ Phone __ - __ - __

City ______________ State ____ Zip ____ E-Mail ______________

Social Security # __ - __ - __ D/L # ______________ State ____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If a minor, parent / guardian name ______________________

Social Security # __ - __ - __ DOB __ - __ - __

Employer ______________________ Phone __ - __ - __

Address ______________________ Ext or Dept ____________

City ______________ State ____ Zip ____ Hours ____________

Occupation ______________________ Supervisor ____________

Spouse ______________________ DOB __ - __ - __ Age ____

Social Security # __ - __ - __ Phone __ - __ - __

Employer ______________________ Work __ - __ - __

Address ______________________

City ______________ State ____ Zip ____

Emergency Contact ______________________ Relationship ____________

Address ______________________ Phone __ - __ - __

City ______________ State ____ Zip ____

Referring Physician ______________________ Next Visit ____________

Primary Care Physician ______________________ Next Visit ____________

How did you hear about Anchor Physical Therapy?: ______________________

____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature ______________________ **Date** ____________