PATIENT INFORMATION

Patients Name_____

Home Phone_____ **Mobile**_____ **May we text you? Y**_____ **N**_____

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Other Sex: ____(M)_____(F)

Birthdate_____**Email**_____**May we email you? Y**_____ **N**_____

Address_____**(City)**_____**(Zip)**_____

Employer_____ **Status ( ) Full Time ( ) Part Time ( ) Retired ( ) Not Employed**

How did you hear about us? _____

POLICY HOLDER (If other than the patient)

First name_____ **MI** _____ **Last** _____ **Birthday** _____

Address_____ **City**_____ **Zip**_____

Relationship to patient: _____ **Employer:**_____

Policy number_____ **Group number** _____

SECONDARY INSURANCE

First name_____ **MI** _____ **Last** _____ **Birthday** _____

Address_____ **City**_____ **Zip**_____

Relationship to patient: _____ **Employer:**_____

Policy number_____ **Group number**_____

EMERGENCY CONTACT INFORMATION

Name_____**Relationship to patient**_____

Home Phone_____ **Work Phone**_____**Mobile**_____

RELEASE AND ASSIGNMENT: I, the undersigned certify that I (or my dependent), have insurance coverage with the above listed insurance company and assign directly to Anchor Physical Therapy all insurance benefits. I understand that I am financially responsible for all charges that are not payable by insurance. There will be a 1% per month (12% annum) service charge posted to all accounts where no payment has been received. There will be a $30.00 return check fee. **I understand that it is my responsibility to check with my insurance to see what my benefits will be and if my plan pays in or out of network. I realize that you have verified this, however, that it is not a guarantee of benefits or payments.** I also authorize the release of my medical and billing information to my insurance company and Physician if requested.

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Patient Signature (if under 18, parent/guardian must sign) **Date**