PATIENT INFORMATION

Patients First Name________________________ MI_______ Last__________________________________

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 ( ) Student

How did you hear about us? ____

Is this auto accident related? Yes_____ No_____ If yes, auto insurance name: _______________________

Adjustors name_______________________________ Adjustors phone number_______________________

Claim number: _______________________________

POLICY HOLDER

Insurance: ___________________________________ Relationship to patient: ________________________

First name_____________________ MI_____ Last _____________________ Birthday ________________

Address____ City______________ Zip____________________

Policy number________________________________ Group number _______________________________

SECONDARY INSURANCE

Insurance ____________________________________ Relationship to patient ________________________

First name_____________________ MI _______ Last __________________ Birthday _________________

Address____ City______________ Zip____________________

Policy number________________________________ Group number______________________________

EMERGENCY CONTACT INFORMATION

Name ____Phone ____

Relationship to patient ____

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, keep track of authorized visits and verify 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.

Patient Signature ____Date ________________________

(if under 18, parent/guardian must sign)