



**PATIENT INFORMATION**

Patient 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.

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

Date

\*Anchor Physical Therapy is a weapon and drug free zone. For the safety of our patients and staff members, we kindly ask that you do not enter the building while in possession of a weapon or illegal substance.