WELCOME SHEET

PATIENT INFORMATION

Full Name: _____ Today's Date: _____

Home Address: _____ Age: _____ Gender: M F

City, State, Zip: _____ Cell Phone: _____

Email Address: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Spouse's Name: _____

Occupation: _____ Employer Name: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

Primary Care Doctor: _____ Doctor Phone: _____

* How did you hear about our clinic?
( ) Doctor ( ) Patient ( ) Yellow pages ( ) Drive By ( ) Internet: _____ ( ) Other: _____

* Whom may we thank for referring you? _____ Have you visited our website? Y N

* If you have visited our website, did you use it to: ( ) Find a PT ( ) Research Pinnacle PT ( ) Get Directions ( ) Other:

* Preferred method of receiving bills: ( ) Mail ( ) Email: _____

ACCIDENT INFORMATION

Is this condition due to an accident? Y N Date of accident: _____

Type of accident: ( ) Auto ( ) Work ( ) Home ( ) Other Do you have an attorney? Y N

Attorney Name: _____ Attorney Phone: _____

INSURANCE INFORMATION

Name of insurance company: _____

ID #: _____ Claim or Group #: _____

Insured's Name if different than yours: _____

Relationship to Insured: _____ Birth Date: _____ / _____ / _____ Employer: _____

SECONDARY INSURANCE INFORMATION (Any coverage in addition to primary)

Name of insurance company: _____

ID #: _____ Group #: _____

Insured's Name if different than yours: _____

Relationship to Insured: _____ Birth Date: _____ / _____ / _____ Employer: _____

Assignment and Release:

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Pinnacle Physical Therapy all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Pinnacle Physical Therapy may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____