PATIENT INFORMATION FORM

First Name_______________________________________ Last Name______________________________________
Address____
City______________________________________State__________________Zip Code_______________
Birthdate________________ Gender____________
Cell Phone #_____________________Work Phone #_____________________ Home Phone #___________________
Email____ Social Security #________________________________
Referring Physician____Diagnosis_________________________________
Employer____
Employer Address____
Emergency Contact______________________________________Phone#____________________Relationship_________
Emergency Contact______________________________________Phone#____________________Relationship_________
How did you hear about us? _______________________________________

PRIMARY INSURANCE INFORMATION

Insurance Name____
Policy Holder's Name____ Social Security #_____________________
Policy Holder's Date of Birth_______________________
Policy #____Group #___________________________________

SECONDARY INSURANCE INFORMATION

Insurance Name____
Policy Holder's Name____Social Security #_____________________
Policy Holder's Date of Birth_______________________
Policy #____Group #____________________________________

MEDICAL INFORMATION

PLEASE CHECK ALL THAT APPLY

HEART ATTACK_________________	HEADACHES________	ANEMIA________________
HIGH BLOOD PRESSURE__________	STROKE_________	TUBERCULOSIS___________
LOW BLOOD PRESSURE__________	DIZZINESS________	CURRENTLY PREGNANT________
ANGINA____________	FAINTING_________	DIABETES________
PACEMAKER_________	BLURRED VISION________	EMPHYSEMA________
ANGIOPLASTY_________	EPILEPSY_________	CANCER_________
HEART MURMUR_________	ARTHRITIS________	SPRAIN/STRAIN__________
CARDIAC BYPASS__________	ALLERGIES________	FRACTURE__________

OTHER____
CURRENT MEDICATIONS____

PAYMENT AUTHORIZATION

I understand that I am fully responsible for any balance incurred at Koop Family Physical Therapy, LLC. I also request that payment should be made to Koop Family Physical Therapy, LLC.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical information necessary to process insurance claims and any holder of medical information about me to release any such information needed to determine these benefits payable to related services.

AUTHORIZATION TO RECEIVE TREATMENT

I authorize treatment to be rendered by Koop Family Physical Therapy, LLC.

____ __________________
Signature of patient/legal guardian (if under 18 years of age) Date