

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 us? _____ 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 _____