Patient Information

First Name _____ Last Name_____ SSN: _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Employer & #: _____

Sex: [ ] M [ ] F Birth date: _____ Age: _____ [ ] single [ ] married [ ]widowed [ ] divorced [ ] separated

Who can we thank for referring you to A-Team Physical Therapy? (MD office/former patient) _____

Referring MD: _____Telephone #_____

Is your injury due to an accident? [ ] yes [ ] no If yes, [ ] work [ ] auto [ ] other - Date and State of Accident: _____

Attorney Name: _____ Attorney Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary insurance

Insurance Co. _____ Policy/ID # _____

Policy holder name _____

Policy holder DOB _____ policy holder SSN# _____ relation to patient _____

Policy holder address _____

Employer _____ Phone# _____

Secondary/supplemental Insurance

Insurance Co. _____ Policy/ID # _____

Policy holder name _____

Policy holder DOB _____ policy holder SSN# _____ relation to patient _____

Policy holder address _____

Employer _____ Phone# _____

Guarantor Information: (person accepting responsibility for the payment of another's debt in the event of default)

Name _____ Address _____

Please read: all charges are due at the time of service. The patient or guarantor is responsible for furnishing insurance claim information and referral to our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments.

I hereby authorize A-Team Physical Therapy LLC. To render treatment by a licensed therapist, to furnish information to insurance carriers concerning my illness and treatments, and, hereby assign to the provider all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient/Guarantor Signature: _____ Date _____