WELCOME TO FORSTER PHYSICAL THERAPY

NAME:

AGE: BIRTHDATE: SOC. SECURITY#: DRIVER'S LIC #: STATE:

HOME ADDRESS: CITY / STATE: ZIP CODE:

EMAIL ADDRESS: PHONE #: CELL PHONE #:

Who referred you to our office: Are you a member of a club?:

How did you hear abour us: Did you hear about us thru that club:

NAME OF EMPLOYER: OCCUPATION:

BUSINESS ADDRESS:

CITY: STATE: ZIP CODE: AREA CODE/PHONE #:

NAME OF SPOUSE: SPOUSE SOC. SECURITY #:

SPOUSE EMPLOYER: SPOUSE OCCUPATION:

SPOUSE BUSINESS ADDRESS:

CITY: STATE: ZIP CODE: AREA CODE/PHONE #:

INJURY OR CHIEF COMPLAINT: DATE OF INJURY:

IS YOUR INJURY: ☐ WORK RELATED ☐ AUTO RELATED ☐ OTHER

HOW DID IT OCCUR:

IS AN ATTORNEY HANDLING YOUR CASE: ☐ YES ☐ NO

IF YES, ATTORNEY'S NAME: AREA CODE/PHONE/FAX #:

ADDRESS: CITY: STATE: ZIP CODE:

INSURANCE CO: CERT. OR POLICY NUMBER:

INSURED OR SUBSCRIBER'S NAME: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

BILLING ADDRESS (IF DIFFERENT FROM ABOVE):

CONTACT PERSON: AREA CODE/PHONE #:

IN CASE OF EMERGENCY: RELATIONSHIP:

PHONE #: HOME: WORK: CELL:

REFERRING PHYSICIAN: AREA CODE/PHONE #:

DO YOU HAVE OR HAVE YOU EVER HAD (PLEASE CHECK) ☐ ANEMIA ☐ ASTHMA ☐ EPILEPSY ☐ HEART CONDITION ☐ HEPATITIS ☐ HYPERTENSION

ARE YOU TAKING ANY MEDICATION: IF SO, FOR WHAT:

IF ALLERGIC TO ANY MEDICATIONS, PLEASE INDICATE:

WHAT FITNESS ACTIVITIES DID YOU TAKE PART IN PRIOR TO THIS INJURY:

FREQUENCY PER WEEK: LENGTH OF WORKOUT: TIME: MILES:

I hereby authorize the release of any information related to all claims submitted on my behalf of myself and/or dependents. I hereby assign to Forster Physical Therapy, all benefits provided by my insurance policy for professional services rendered and agree to pay all charges not covered by my insurance policy. If my insurance pays me directly it is my responsibility to forward the payments for the services that were rendered to me. If I fail to do so I will be asked to pay in full the current balance on my account. I understand that I am fully and completely responsible for the knowledge of my policy benefits and limits, including number of visits payable on my policy. I will stay within my financial capabilities in this regard. I understand that to avoid being charged for a missed appointment, I need to call 24 hours in advance to cancel it.

PATIENT SIGNATURE DATE

SIGNATURE OF PARENT OR GUARDIAN

WITNESS DATE

PLEASE PRINT NAME OF PARENT OR GUARDIAN