

PATIENT INFORMATION SHEET

PATIENT: (Please provide your legal name as it appears on your insurance card)

Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone# _____ Work Phone #: _____ Ext _____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____ - _____ - _____ Gender: M F Martial Status: M S D W

Employer Name: _____ Occupation: _____

Employer Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill.

RP Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ Relationship to Patient _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone# _____ Work Phone #: _____ Ext _____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____ - _____ - _____ Gender: M F Martial Status: M S D W

Employer Name: _____ Occupation: _____

SPOUSE or GUARDIAN:

Last Name: _____ First Name: _____ Middle: _____

Employer Name: _____ Work Phone #: _____

Date of Birth: ___ / ___ / ___ SS #: _____ Employer: _____

INSURANCE: (please list insurance name and provide a copy of your card to the receptionist)

1st Insurance Company: _____ Phone# _____

Insured's Name: _____ ID/Policy #: _____ Group# _____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____ - _____ - _____ Gender: M F Martial Status: M S D W

If Medicaid: Which Doctor is your Passport Provider ? _____

2nd Insurance Company

Insured's Name: _____ ID/Policy #: _____ Group# _____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____ - _____ - _____ Gender: M F Martial Status: M S D W

****If Workers Compensation or Motor Vehicle Accident or Personal Injury Please complete the attached form****

EMERGENCY Name and address of nearest relative or friend **not living with you:**

Last Name: _____ First Name: _____ Relation to Patient: _____

Home Phone #: _____ Work Phone #: _____

Authorization Form 001

I hereby assign, transfer and set over to Hamilton Physical Therapy & Sports Rehabilitation Center and or it's individual Therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____ Date _____