PHYSICAL THERAPY SERVICES OF WILMINGTON

(Patient Information and Authorization Form)

PATIENT'S FULL NAME: _____ BIRTHDATE ___/___/___

SOCIAL SECURITY # _____ AGE ____ Weight:_____ Height: _____

ADDRESS _____

_____

(City) (State) (Zip Code)

PHONE 1:_____ PHONE 2: _____ E-MAIL: _____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

HAVE YOU RECEIVED ANY THERAPY THIS CALENDAR YEAR? YES NO

HAVE YOU FALLEN IN THE LAST YEAR? YES NO

PAIN LEVEL TODAY (0 being no pain at all, 10 being the worst pain)
(Please circle one): 0 1 2 3 4 5 6 7 8 9 10

OCCUPATION: _____EMPLOYED BY _____

HOW DID YOU HEAR ABOUT US? _____

REFERRING PHYSICIAN: _____ DATE OF ONSET: _____

HOW DID PROBLEM/INJURY HAPPEN? _____

WORKMEN'S COMPENSATION (please circle one): YES NO

IF YES, NAME OF EMPLOYER RESPONSIBLE _____

WORKER'S COMP ADJUSTER NAME/NUMBER_____

ATTORNEY: _____

INSURANCE: _____ ID # _____ GROUP # _____
(Company Name)

SECONDARY INSURANCE: _____ ID # _____ GROUP # _____
(Company Name)

AUTHORIZATION (PLEASE READ & SIGN)

I hereby authorize Physical Therapy Services of Wilmington to furnish information to insurance carriers and physicians concerning illness and treatments rendered to myself and/or my dependents and I authorize payment directly to Physical Therapy Services of Wilmington for services rendered. I understand that I am responsible for ALL MEDICAL EXPENSES whether or not there is insurance coverage or an accident with another person at fault.

_____ _____

(Date) (Signature of patient or legally responsible adult)