# 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)