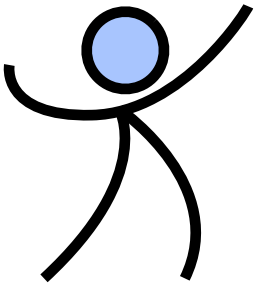

Total Care Physical Therapy

Therapy / Massage / Rehabilitation

Patient Information Form

Patient Last Name:_____ First Name: _____ MI: _____

Home Phone: _____ Work:_____ Mobile:_____

Address (Permanent): _____ City, ST Zip:_____

Address (Seasonal): _____ City, ST Zip:_____

Date of Birth: _____ Age:_____ Sex: ____ Marital Status: _____

Social Security Number: _____ Occupation: _____

Employer: _____ Employer Address:_____

Referral Source: _____

Information of the person responsible for payment of medical bills:

Relationship to patient: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age:_____ Sex: ____ Social Security Number: _____

Insurance Information:

Check all that apply: ☐ Medicare ☐ Medicare Supplement ☐ HMP/PPO ☐ Worker's Comp ☐ Auto Insurance

Insurance Carrier:_____ Telephone: _____

Policy #: _____ Group #: _____ Claim #: _____

I, _____, hereby authorize Total Care Physical Therapy & Fitness to render to the patient that which the patient's treating physician and physical therapist determines necessary or advisable. It is further understood that this clinic is hereby relieved of all liability occurring from the performance of the physician's instructions. I certify that all of the information provided to Total Care Physical Therapy & Fitness is true and accurate and I authorize Total Care Physical Therapy & Fitness to disclose any information including all or part of the patient's record, to any physician, government agency, insurance company or health care facility, workman's compensation carriers, welfare funds or the patient's employer.
The undersigned certifies that he/she has read the above agreement and is the patient or is authorized by the patient's general agent to execute the above and accept it's terms:

Patient or Patient's Legal Guardian's Signature: _____ Date: _____