



DATE:

APPOINTMENT DATE:

Patient Information										
REFERRING PHYSICIAN		LAST NAME			FIRST NAME, INITIAL			DATE OF BIRTH		
CONDITION TO BE SEEN FOR			SOCIAL SECURITY NO.		DRIVERS LICENSE NO.		SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED		
ADDRESS					CITY		STATE	ZIP CODE		
EMAIL ADDRESS		OCCUPATION		HOME PHONE		WORK PHONE		CELLPHONE		
EMPLOYER		EMPLOYER ADDRESS			CITY		STATE	ZIP CODE		
Responsible Party Information Other Than Patient										
RESPONSIBLE PARTY OR CUSTODIAL PARENT			GUARANTOR NAME (LAST, FIRST,MIDDLE)				SOCIAL SECURITY NUMBER			
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE		WORK PHONE		CELLPHONE		RELATION TO PATIENT		
ADDRESS					CITY		STATE	ZIP CODE		
EMPLOYER		EMPLOYER ADDRESS			CITY		STATE	ZIP CODE		
Emergency Contact										
CONTACT NAME			RELATION TO PATIENT		HOME PHONE		WORK PHONE		CELLPHONE	
<p>I Understand that regardless of my insurance, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Pillars Physical Therapy on my behalf for any unpaid services rendered by Pillars Physical Therapy.</p>										
SIGNATURE						DATE				
Insurance Information										
TYPE OF INSURANCE: <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> HEALTH <input type="checkbox"/> SELF PAY <input type="checkbox"/> WORKERS' COMP. <input type="checkbox"/> OTHERS _____										
PRIMARY INSURANCE COMPANY			PHONE NUMBER		GROUP NUMBER		ID/SS NUMBER			
EFFECTIVE DATE		RELATIONSHIP TO SUBSCRIBER (INSURED)		SUBSCRIBERS NAME			SUBSCRIBERS DATE OF BIRTH			
PRIMARY INSURANCE COMPANY ADDRESS				CITY		STATE	ZIP CODE			
DEDUCTIBLE		DEDUCTIBLE BALANCE		YEARLY OR LIFETIME MAX		MAX YEARLY VISITS		CO-PAY		
SECONDARY INSURANCE COMPANY			PHONE NUMBER		GROUP NUMBER		ID/SS NUMBER			
EFFECTIVE DATE		RELATIONSHIP TO SUBSCRIBER (INSURED)		SUBSCRIBERS NAME			SUBSCRIBERS DATE OF BIRTH			
SECONDARY INSURANCE COMPANY ADDRESS				CITY		STATE	ZIP CODE			
CASE MANAGER		PHONE		FAX		ADJUSTER		PHONE		FAX
CASE/CLAIM NO.		CLAIM BILLING ADDRESS					DATE OF INJURY			
CONTACT PERSON					NOTED BY					