Account Number _____ Appointment Date:_____ Appointment Time:_____

Lattimore Physical Therapy and Sports Rehabilitation Network
Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information needs to be completed. Information will be confidential.

Patient Name_____ Male____ Female____ D.O.B.____/____/_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____ SSN_____-_____-_____

Referring Physician_____ Phone_____

Primary Care Physician _____ Phone_____

Body part(s) being treated_____ **RIGHT** **LEFT**

Emergency contact: _____Relationship _____Phone:_____

Any restrictions: _____

May we leave a message? Y or N **Restrictions example: financial or PHI information**

How did you hear about Lattimore Physical Therapy? _____

Do you have a prescription from the physician? YES NO (please circle)

Date of Injury or Onset: _____ Date of Surgery (if applicable): _____

Have you received physical therapy this year YES or NO If Yes, was it for the same condition? Yes or NO

Is this in any way related to **Workers Comp** or **No Fault? YES NO (please circle) (if yes, please fill out the attached worker's comp and no fault insurance sheet and your backup medical insurance below)**

ATTENTION MEDICARE PATIENTS: Are you receiving home health services of any kind YES_____ NO_____** IF YES, PLEASE SEE RECEPTIONIST – PT SERVICES MAY NOT BE COVERED**

1) PRIMARY INSURANCE INFORMATION

Insurance company _____ ID#_____

Subscriber: _____

Subscriber Date of Birth: _____ Relationship to patient: _____

2) SECONDARY INSURANCE INFORMATION

Insurance company _____ ID#_____

Subscriber: _____

Subscriber Date of Birth: _____ Relationship to patient: _____

Patient name: _____

Patient Signature: _____ **Date:** _____