ENCHANTED LAKE PHYSICAL THERAPY

PATIENT INFORMATION

Last Name: ______________________________________ First Name: _____________________________ M.I. ____________________

Home Address: ____ City: ______________________ State: _______ Zip Code: ______________

Age:________ Sex: □Male □Female Marital Status: □Single □Married □Other Date of Birth: _________________________

Home Phone: ______________________________ Cell Phone: ______________________________ E-mail: ______________________________

□Employed □Student □Retired □N/A Employer /School Name: _____________________________ Title/Position: _________________________

Work Address: ______________________________ City: ________________ State: ______ Zip Code: __________ Work Phone: _____________

Have you received PT/OT for this diagnosis? □Yes □No Have you received PT/OT for any other conditions this calendar year? □Yes □No

REFERRING INFORMATION (How did you hear about us?)

Last Name: _____________________________ First Name: _______________________ M.I. ______ Office Phone: _________________________

Date you were last seen by your referring physician: _____________ Next appointment date with your referring physician: ______________________

How did you hear about us? □Patient □Friend/Family □Yellow Pages □Other: ____

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATON

Emergency Contact: _______________________________ Relationship: ___________________ Phone (Home/Cell): ________________________

Legal Guardian: ____ Phone(Home/Cell): ____

Address: ____ City: _____________________ State: _______ Zip Code: ________________

Primary Care Physician: _____________________________________ Office Phone: ____

INSURANCE INFORMATION

Primary Insurance: _____________________________________

Policy No. ____

Group No. ____

Insured Name: ____________________________________ _____

Pt's relationship to insured name: __________________________

DOB: _________________ SSN: ___________________________

Secondary Insurance: _____________________________________

Policy No. ____

Group No. ____

Insured Name: ____

Pt's relationship to insured name: ___________________________

DOB: __________________ SSN: ___________________________

Medicare:

Have you received PT services at home within the last 2 months? □Yes □No

Are you currently receiving any therapy at another facility or hospital? □Yes □No

TriCare/TriWest:

Are you currently on active duty? □Yes □No

Do you have a letter of authorization to see us? □Yes □No

Worker's Compensation/Auto Information:

Insurance Company: ____________________________________

Address: ____

City, State, Zip: ____

Adjuster: ____

Phone: ____

Claim No. ____

Attorney Involved? □Yes □No

Attorney Name: ____

Attorney Address: ____

City, State, Zip: ____

Phone: ____

Auto Only: Policyholder: __________________________________ Relationship: ____________________ Auto Policy No. ______________________

APPOINTMENT CANCELLATION POLICY

If you are unable to keep your appointment please RESCHEDULE or CANCEL your appointment at least 24 hours in advance. If you should have (3) appointment cancellations with inadequate notice, or (2) "no shows" for scheduled appointments we will cancel any remaining appointments, notify your physician, and discharge you as a patient. We have 24 hour answering machines for your convenience during non-working hours, weekends, and holidays.

I certify that the information I have provided above is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

____ ______________________________ _______________________

Patient / Parent / Guardian Signature Relationship to Patient Date