

Welcome

Thank you for selecting Southside Physical Therapy. We will strive to provide you with the best possible physical therapy care. To help us meet your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help. All information is confidential.

Referring Physician _____ **Family Physician** _____

Name _____ **Phone #** _____

Address _____

City _____ **State** _____ **Zip** _____

Birth Date _____ **Social Security #** _____

Employer _____ **Phone #** _____

Address _____

City _____ **State** _____ **Zip** _____

Spouse/Parent _____ **Social Security #** _____

Employer _____ **Phone #** _____

Employer's Address _____

City _____ **State** _____ **Zip** _____

Emergency Contact (other than above)

Name _____ **Phone #** _____ **Relation** _____

Person responsible for payment of bill _____

INSURANCE INFORMATION (We need a copy of your card)

Primary Carrier _____ **Policy #** _____ **Group #** _____

Policy Holder _____ **Relation to Patient** _____

Birthdate _____ **Social Security #** _____

Secondary Carrier _____ **Policy #** _____ **Group #** _____

Policy Holder _____ **Relation to Patient** _____

Birthdate _____ **Social Security #** _____

Was this due to an injury? Yes/No **Work Related?** Yes/No

Auto Related? Yes/No

Date of injury? _____ **Time of injury?** _____

Date first obtained medical treatment _____

Workers' Compensation/Attorney Information

Name of Employer/Attorney _____ **Phone #** _____

Address _____ **Contact Person** _____

City _____ **State** _____ **Zip** _____

