Welcome to Alpine Physical Therapy & Spine Care

Last Name _____ First Name _____ MI _____ Nickname/Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ E-Mail _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Employer Name and Address _____

Emergency Contact _____ Relationship to Patient _____ Phone Number _____

How did you hear about APT? Who referred you to our office?_____

Your benefits may be affected by previous treatment elsewhere (visit limits, authorizations, etc) Please note the number of physical therapy visits you've had this year at any other locations: _____

If patient is under age 18, please complete the following:

Name of Parent or Guardian _____ Parent or Guardian SSN _____ Parent or Guardian Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Employer Address _____ Employer Phone _____

Work Injury / Accident Information

Is today's visit a result of a work injury or other accident? _____ NO _____ YES

Accident Date _____ Claim Number _____

Accident Insurance Co. _____ Adjuster Name _____ Adjuster Phone _____

Attorney Name & Phone Number, if applicable _____

Primary Insurance Information (Please inform us if you have a secondary insurance)

(Does not need to be completed if card was presented at front desk for scanning)

Primary Insurance _____ Policy/ID Number _____ Group Number _____

Policy Holder Full Name _____ Policy Holder Date of Birth _____ Relation to Patient _____

Insurance Co. Address _____ Insurance Co. Phone Number _____