

---

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
------------	------------	------------

---

***Work Injury / Accident Information, please complete the following if applicable:***

---

Accident Date	Claim Number	Accident Insurance Co.
---------------	--------------	------------------------

---

Address	Adjuster Name	Adjuster Phone
---------	---------------	----------------

---

Attorney Name & Phone Number, if applicable

---

***-- FOR OFFICE USE ONLY --***

---

Verification Date	Insurance	Phone
-------------------	-----------	-------

---

Policy/ID Number	Group Number	Effective Date	Auth Required
------------------	--------------	----------------	---------------

---

Deductible (met)	Coverage/Co-pay	Visit Limits	Visits Used YTD
------------------	-----------------	--------------	-----------------

---

Authorization/Coverage/Exclusion Details: \_\_\_\_\_

---

---