LANCASTER PHYSICAL THERAPY & SPORTS MEDICINE

Name: _____. **Sex:**_____ **Male** _____ **Female**
(first, middle initial, last)
Address: _____**City:** _____ .
State: _____. **Zip:**_____.

E-Mail Address: _____ **D.O.B.** _____.
Home/Contact Phone: (_____)- _____- _____. **Cell Phone:** (_____)- _____- _____.

Diagnosis: _____. **Date of Onset/ Injury:** _____.

Surgery (related to diagnosis), if any--- Type and Date_____

Additional Information:

Referring Physician: _____. **Family Physician:**_____.
Patient's Employer:_____. **Employer Phone:** _____.

If NO employer, check below:
_____Student, _____Disabled, _____Retired, _____Unemployed

<u>Since January 1 of this year, have you had any….</u> **Auto Related?** Yes or No

PHYSICAL THERAPY?	NO or YES*	**WC Related:** Yes or No
OCCUPATIONAL THERAPY?	NO or YES*	If WC, employer's name_____
SPEECH THERAPY?	NO or YES*	
CHIROPRACTIC CARE?	NO or YES*	

***ANY OF THESE THERAPIES MAY COUNT TOWARDS YOUR AUTHORIZATION OR VISIT LIMIT**
*** If YES to any above. How many visits?_____**

How did you hear about Lancaster PT?

- Dr. _____
- Advertisement/Yellow Pages
- Other _____
- Friend

HIPPA: Other than what is mentioned on the Patient Consent Form, please list any names you give us permission to release or disclose health information:

_____

Emergency Contact Name and Phone #:
(in case something were to happen to you here):
_____.

Insurance Information:

Primary Insurance: **Secondary Insurance:** **Third Insurance:**

<u>Policy Holder Information</u>

Is this for 1st, 2nd or 3rd Insurance?
Name:_____ Address (if different):_____.
Phone: (_____)- _____- _____. D.O.B. _____/ _____ / _____.
Employer:_____Relationship to Patient:_____.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lancaster Physical Therapy & Sports Medicine to release any information required to process my claims.
*Patient/Guardian Signature:*_____*Date:*_____.