UNITED PHYSICAL THERAPY

Date:_____Patient Chart #_____Treating Therapist:

Patient's Name: _____
LAST FIRST

Mailing Address: _____
Street CITY STATE ZIP

SS# :_____Home Phone: _____ Work Phone:_____

Birth Date:_____ Sex: ( )Male / ○ Female Marital Status: _____

Patient's Employer:_____

Spouse's Name _____SS# : _____ Birth Date _____

Spouse's Employer:_____

Reason for visit: _____ Date of Injury _____

Referring Doctor: _____

Have You Been Treated In This Office Before? ( ) Yes ( ) No

Relative We Can Contact in the Event of Emergency:

Name _____ Phone _____
Last First

Address _____
Street CITY STATE ZIP

I plan to Make Payment of Medical Expenses As Follows: (Check One or More)
( ) Cash/Check (} Master card ( ) Visa ( )Medicaid _____
(Present Medicaid Coupon)

Is this Work Related: () Yes () No Auto Accident: () Yes () No

Insurance Name_____ Group# _____

Name of Insured _____ Insured Date of Birth _____

Insured SS# _____Insured Employer _____

Relationship to Employee_____

Patient or Authorized Person's Signature./ I Authorize The Release of Any Medical Information Necessary to Process This Claim I Also Request Payment of Government Benefits Either to Myself or to the Party Who Accepts Assignment Below. / I Authorize Payment of Medical Benefits to Physician or Supplier For Service:

Signed (Insured Or Authorized Person) X _____Date _____