Welcome to Aquacare Physical Therapy
Patient Information Form

Date ____/____/_____ Staff Initials: _____ Diagnosis _____

First Name _____ Middle Initial ____ Last Name _____

Date of Birth _____/_____/_____ Gender: M / F (circle) SSN _____-_____-_____
Month Day Year

Referring Physician _____ Primary Care Physician _____

Have you had prior physical therapy within the LAST YEAR? (Circle One) YES NO IF SO, WHERE? _____
Are you currently receiving Home Healthcare Services? (Circle One) YES NO

How did you hear about us? _____**Email**_____

CONTACT INFORMATION

Cell (_____) _____ - _____ Home (_____) _____-_____ Work (_____) _____-_____

Street _____ City _____ State _____ Zip _____

P.O. Box _____ City _____ State _____ Zip _____

PRIMARY INSURANCE INFORMATION

Insurance Carrier_____ Subscriber ID# _____

Group Number _____ Phone (_____) _____-_____

Insured's Name _____ DOB _____/_____/_____ SSN _____-_____-_____

SECONDARY INSURANCE INFORMATION – (IF APPLICABLE)

Insurance Carrier_____ Subscriber ID# _____

Group Number _____ Phone (_____) _____-_____

Insured's Name _____ DOB _____/_____/_____ SSN _____-_____-_____

IS THIS INJURY WORKERS COMPENSATION RELATED? YES NO

Date of Injury _____/_____/_____ Claim #_____ Work Comp Insurance Carrier_____

Adjustor _____ Phone _____ Employer Name_____

Employer Address _____ Phone (___) _____-_____

IS THIS INJURY AUTO RELATED? YES NO

Date of Injury _____/_____/_____ Claim # _____ Insurance Carrier _____

Adjustor _____ Phone _____ State Accident Occurred_____

LAWYER INFORMATION

Lawyer Name _____ Phone_____ Ext _____

Address _____ City _____ State_____ Zip_____

By signing below, I consent to treatment at Aquacare Physical Therapy for the above named individual. I authorize the release of all medical information necessary to process medical claims. I also authorize the insurance company to make payment directly to Aquacare Physical Therapy for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above named patient.

Signature _____ **Date** _____

OFFICE USE ONLY
Date of Initial Evaluation _____/_____/_____ **Time**_____ **PT**_____

IS THE PATIENT ABLE TO COME IN SOONER? YES NO