

PATIENT INFORMATION FORM

Patient's Name _____ D.O.B. _____ Sex _____ Soc.Sec.# _____
Last First M.I.

Home Address _____ Phone _____
Number & Street City/Town State Zip Area code & #

Patient's Employer _____ Phone _____
Name & Address Area code & #

Spouse's Name _____ D.O.B. _____ Sex _____ Soc.Sec.# _____
Last First M.I.

Spouse's Employer _____ Phone _____
Name & Address Area code & #

Relative whom we can contact in event of emergency:

Name _____ Relationship _____
Last First M.I.

Address _____ Phone _____
Number & Street City/Town State Zip Area code & #

Referred by: () Dr. _____ Phone _____
Physician's Name & Address Area code & #

() Other _____ Phone _____
Name & Address Area code & #

Financial Responsibility Information:

Health Insurance _____ Worker's Comp. Insurance _____ Medicare _____ Other _____

Insurance Information: _____ Phone _____

Secondary Insurance _____ Phone _____

Subscriber's Name: _____ I.D. # _____ Group # _____
Medicare / Certificate #

Attorney Information: _____ Phone _____
Name & Address Area code & #

Injury Information: Is your injury related to work?() an auto accident?() personal injury?()

Explain in detail please: _____

Financial agreement and authorization for treatment:

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I have Insurance coverage, I authorize my insurance company named above to process and pay all claims for services rendered. I understand that if for some reason my insurance company does not pay Finishline Physical Therapy for authorized services, I am financially responsible and will pay Finishline Physical Therapy on behalf of my insurance company, from whom I will seek reimbursement after canceling my debt with Finishline Physical Therapy.

If treatment received is for a personal injury where a third party insurance or attorney is involved, I agree to sign a lien against any settlement received by me and/or my attorney. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me, I/we agree to pay reasonable attorney's fees and/or other such costs as the Court determines proper.

Signature _____ Date _____

Please provide this office with copies of the following cards: Health Insurance Card, and your Drivers License