PT _____

WEST BILLINGS PHYSICAL THERAPY

3307 GRAND AVE, STE 203
BILLINGS, MT 59102

First Name___________________________________ **M I** ______ **Last Name**______________________________________

Date of Birth________________________ **Age:** _______**SSN#**______________________________ **Sex:** **M**______ **F**______

Home Address____**City**____________________**State**______**Zip**________________

Home Phone#______________________ **Work Phone#**______________________ **Cell/Other Phone#**___________________

Employer ____

Parent/Guardian/Spouse: **Name**____ **Birthdate:** ______________________
(Responsible Party)

Address: ____

City________________________________ **State**______________ **Zip**__________________

Injury Description: ____ **Date of Injury** _________________________

Referring Physician: ____

INSURANCE INFORMATION

Primary Insurance ____ **Policyholder Birthdate:** ______________________

Policyholder SS# (if Insurance ID #) __________________________ **Relationship to Patient**____________________

If *MEDICAID*, please provide PASSPORT PROVIDER: ____

Secondary Insurance ____ **Policyholder Birthdate:** _______________________

Policyholder SS# (if Insurance ID #) __________________________ **Relationship to Patient**____________________

________ **WORK COMP (complete attached info sheet)**

________ **VEHICLE ACCIDENT (complete attached info sheet)**

________ **ATHLETIC INJURY? School Insurance** ____

___ **I, (we) the undersigned patient and/or responsible party hereby do not authorize the release of medical, billing and/or appointment information to persons other than myself (excluding insurance company and referring physician).**

___ **I, (we) the undersigned patient and/or responsible party do hereby authorize this office to release medical, billing, and appointment information to the following members in lieu of myself (ie: spouse, relative):**

1) _____________________________________ **2)** ____

____ ________________________________
Responsible Party Signature **Date**
****by signing this form you are providing consent to be treated**