



Physical Therapy Patient Information Form

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