RETURNING PATIENT DEMOGRAPHIC FORM

Date: _____
Patient Name: _____ Marital Status: S/M/D
Date of Birth: _____ Patient SS#: ___-__-____
Name of Employer: _____ Employment Related: Y/N
Is this related to an accident? Y/N Auto: ____ Other: ____
If other, please specify: _____
Date of Injury: _____
Name of Attorney (if accident related): _____ Phone Number: _____
Referring MD: _____ Primary MD:_____
Emergency Contact: _____ Phone number: _____
Name of Insured: _____ Insured's Date of Birth: _____
Insured's Employer: _____ Patient's Relationship to Insured: _____

Please Fill Out Following Section If ANY Information Has Changed Since Last Course of Treatment

Address: _____
City: _____ State: _____ Zip: _____
Home Ph: ( ) _____ Cell: ( ) _____
Work: ( ) _____Ext_____
E-mail Address: _____ Not interested in supplying: _____
Permission to send information: Yes No
(Your email address is only for the use of Freedom Physical Therapy Services & will not be shared.)
If patient is a minor: Mother's/Guardian Name: _____
Father's/Guardian Name: _____
Address (if different than patient): _____

----------For Office Use Only ----------

Insurance: _____ In Network Out of Network
What is the Deductible? _____ Met Not Met Co-pay:_____
What percent do they pay? _____
Does a physician's referral need to be called in? No Yes _____
If not, do we need a physician's referral at all? No Yes_____
Is there a limit on visits? BMN or_____# visits remaining_____
Do we need to pre-certify treatments? No Yes_____
Are orthotics covered? No Yes_____
Name: _____
Date: _____ Time: _____ Initials: _____

Please Note: You are responsible to know your level of coverage with your insurance company and whether you need to be pre-certified for any therapy treatment. As a courtesy to you, we do call on your benefits but we cannot guarantee the accuracy of the information we receive. You are responsible for any financial discrepancies that may occur if the benefits we are quoted are incorrect.

Did you verify your insurance benefits after your initial phone call with Freedom Physical Therapy?

(*Please initial*) Yes_____ No_____

My benefit coverage has been explained to me. I understand I am financially responsible for any discrepancies.

_____
Patient Signature Date

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.
ENJOY MORE FREEDOM™