PATIENT DEMOGRAPHIC FORM

Patient name: _______________________________________ Date of birth: ___________________

Social Security #:_____________________________ Marital Status: S M D

Address: _________________________________ City:________________ State: ____ Zip: ________

Phone Numbers: Home ________________ Cell _________________Work __________________

May we call you with appointment reminders & leave a message? YES NO Text message? YES NO

Email address:________________________________ May contact you via email? YES NO

Emergency contact & relationship: ____________________________________ Phone: _______________

Who can we thank for referring you (circle)? Physician Friend/family Web Other: _____________

If friend/family, name: ____________________________ Contact info:____________________________

Referring MD: ________________________________ Primary MD: _________________________________

Name of insured:_______________________________________ Insured date of birth: _______________

Insured's employer:______________________________ Patient's relationship to insured: _____________

Is this related to an accident? YES NO If yes, what type? Auto Work Other

Name of Attorney:______________________________________ Phone number: ________________

Is this related to work: YES NO If so, please complete the following:

Date of injury:_________________ Have you filed for worker's compensation YES NO

Name of employer: _______________________________________ Phone number:_______________

Name of employer contact:_________________________________ Phone number:_______________

Name of Case Manager: ___________________________________ Phone number:_______________

Are you off of work due to this injury? YES NO If off work, how long:________________

If working, current work status (circle 2): Part Time or Full Time Regular Duty or Light Duty

For Office Use Only

Insurance: _________________________________ In Network Out of Network

Deductible: _______________(Met/Not Met)* Insurance Pays: _________ Co-pay:__________

Visit Limit: BMN or_______________# visits remaining________________

Physician Rx Needed: No Yes Pre-Authorization: No Yes Orthotic Coverage: No Yes

***discuss cash pay plan if high deductible**

Please Note: You are responsible to know your level of insurance coverage and if you need to be pre-certified for therapy treatment. As a courtesy to you, we call to check your benefits but 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 or change.

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

Patient/Parent/Guardian Signature _________________________________ Date _______________