Patient Data Sheet

CREST PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First MI

Social Security No.:_____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____
OK to leave detailed message? ❑ Yes ❑ No

Cell Phone: _____
OK to leave detailed message? ❑ Yes ❑ No

Work Phone: _____
OK to leave detailed message? ❑ Yes ❑ No

Email Address: _____ Preferred method of contact: _____

Notify in case of Emergency: _____ Phone number: _____

Race: ❑ Am Indian ❑ Asian ❑ Native Hawaiian or Pac Islands ❑ White ❑ Other Ethnic Background: ❑ Hispanic/Latino Non-Hispanic/Latino

Smoking Status: ❑ Every Day Smoker ❑ Some Day Smoker ❑ Former Smoker ❑ Never Smoker ❑ Unknown

SUBSCRIBER

Relationship to patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Name: _____ Birthdate: _____

Address: _____

Employer: _____ Employer address: _____

Home Phone: _____ Work Phone: _____ Social Security No. _____

Sex: ❑ M ❑ F Employer: _____ Occupation: _____

ACCIDENT INFORMATION

Did you have Surgery: ❑ Yes ❑ No Surgery Date: _____ Accident/Injury type: ❑ Workers Comp* ❑ Auto ❑ Other:

Accident / Injury Date / Date Doctor was seen for this problem: ____/____/____ Briefly describe accident: _____

*If Worker's Comp - Employer: _____ State: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Primary Insurance Name: _____ Phone: _____

Policy / Claim #: _____ Group # : _____

Insured Name: _____ Authorization / Pre-Certification: _____

Secondary Insurance Name: _____ Phone: _____

Policy / Claim #: _____ Group # : _____

Insured Name: _____ Authorization / Pre-Certification: _____

********** OFFICE USE ONLY **********

Referring Physician:_____ Phone #: _____ UPIN #: _____

Admit Date: ____/____/____ RX Date: ____/____/____ Therapist Name: _____

Body Part / PT / OT / DURATION: _____

Service Class: _____ FSC Code: _____ Intake Completed By: _____

Have you received physical therapy, occupational therapy, or chiropractic services in the past year? ❑ Yes ❑ No

This information will be used for billing purposes; please present your insurance card and a photo id to the front desk receptionist. I have reviewed the above information and verify that it is correct.

Patient / Guardian signature: _____ Date: _____

