Total Health Physical Therapy
Patient Information

Name____BirthDate_____________M__F__
First Middle Initial Last

Mailing Address____

City__________________________State___________________Zip Code____________________

CONTACT INFORMATION

Home phone________________________Cell Phone___________________________________

Work phone_________________________E-Mail Address________________________________

Emergency
Contact Name_____________________Phone____________________Relationship_____________

Primary Care Doctor_____________________________________Phone______________________

WORKER'S COMP PATIENTS:

Date of Injury____________________________Social Security Number____________________

Employer____Phone___________________________

Employer Address____

Claim number___________________________Claim Manager______________________________

I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

I understand and agree that although every attempt to collect from my insurance will be made, I am ultimately responsible for the balance of my account for any professional services rendered.

Signature____Date________________________________

Revised 05-2018