Patient Information Form

ADVANCED PHYSICAL THERAPY and Sports Rehab
Therapy with a heart!

Clinic Location: North___ East___ Liberty ___

Date		***APT ID (Staff Only)***	
Patient's Name		Birth Date	
Social Security #		Gender	
Address		City	
State / Zip Code		Home Phone	
Marital Status		Cell Phone	
Patient E-mail Address			
Patient Employer		Employer Phone #	
Emergency Contact		Emergency Phone	
Emergency Contact Relationship to Patient			

Referring Physician		Diagnosis	
Script date/Frequency		Diagnosis 2	
Injection Date		Evaluation Date	
Date of Onset		Date of Surgery	
Follow Up Appointment Date with Dr.			

Has Pt ever had P.T. before		If so was previous P.T. with us	
Injury (Work/Auto)		Visit # used this year	
Home Health (yes/no)		Last Home Health Date	

Insurance		Insurance Phone #	
Policy / Claim #		Group #	
Policy Holder Name		Policy holder DOB	
Policy holder Phone #		Relationship to Patient	
Policy holder Address		City	
State / Zip Code		Policy holder Employer	

Secondary Insurance		Insurance Phone #	
Policy / Claim #		Group #	
Policy Holder Name		Policy holder DOB	
Policy holder Phone #		Relationship to Patient	
Policy holder Address		City	
State / Zip Code		Policy holder Employer	

Who may we thank for sending you to Advanced Physical Therapy? _____

M.D. _____ **Friend** _____ **Insurance Co.** _____ **Internet** _____ **Other** _____