

**PATIENT INFORMATION**      **Account Number** \_\_\_\_\_

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ City & Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Phone number to be used as the primary contact number \_\_\_\_\_

Sex M / F (Circle one)    Marital Status \_\_\_\_\_ Spouse's Name & Work # \_\_\_\_\_

Responsible Person's Name, Address & Phone # (for patient's under 18) \_\_\_\_\_

Date you last saw your referring and/or primary physician: \_\_\_\_\_

Referring Physician \_\_\_\_\_  
(First and last name) (City)

Primary Physician: \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Occupation \_\_\_\_\_

**FOR ALL PATIENTS**

Have you had physical therapy or chiropractic care in the past year \_\_\_\_ Yes \_\_\_\_ No

If yes, please state where: \_\_\_\_\_

**HMO PATIENTS ONLY**

Have you ever received physical therapy for this diagnosis before? \_\_\_\_ Yes \_\_\_\_ No

If yes, please state when: \_\_\_\_\_

**INSURANCE INFORMATION**

Please check all that apply

\_\_\_\_ Blue Cross/Blue Shield    \_\_\_\_ Medicare    \_\_\_\_ HMO/PPO/POS  
\_\_\_\_ Motor Vehicle Accident    \_\_\_\_ Workers Comp    \_\_\_\_ Private Pay Insurance

DATE OF ILLNESS OR INJURY: \_\_\_\_\_

**How did you hear about First Choice Rehab**

\_\_\_\_ Doctor    \_\_\_\_ Radio    \_\_\_\_ Newspaper    What radio station(s) do you listen to? \_\_\_\_\_  
\_\_\_\_ Friend    \_\_\_\_ Television    What television station(s) do you watch? \_\_\_\_\_  
What newspaper do you read? \_\_\_\_\_

**CONSENT, RELEASE AND ASSIGNMENT:** I hereby authorize First Choice Rehabilitation Specialists, P.C. to furnish medical information to my insurance carrier concerning this illness or accident, and I assign my insurance benefits to be paid directly to First Choice Rehabilitation Specialists, P.C. If my account becomes delinquent and is sent to a collection agency, I am aware that a 33% collection fee will be added to the balance. I understand that I am financially responsible for non-covered services, deductibles, co-pays and co-insurance and that payment is due on the date the service is provided. I hereby authorize the Physical Therapist or their Assistant to render treatment and procedures in my care. I certify that answers given herein are true and complete to the best of my knowledge.

Patient (or Guardian) Signature: \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARDS TO COPY**