

Grand Island Physical Therapy

Date: _____

PATIENT INFORMATION

Date of Birth:	Last Name:	First Name:
Preferred Name:	Middle Name:	SSN:
Gender (Circle One): Male / Female / Other / Prefer Not to Say		Marital Status (Circle One): Married / Single / Divorced / Widowed
Mailing Address:		City:
State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:
Email:	Would you like appointment reminders? (Circle One): Email Text	
Employer:	Preferred Spoken Language:	

EMERGENCY CONTACT

Name & Relationship:	Phone:
How did you first hear about us? Circle one:	
Family or Friend	TV
Radio	Social Media
Internet Search	Other: _____

REASON FOR VISIT

Have you had any Speech, Occupational, or Physical Therapy this calendar year? Y / N	
Any Chiropractic visits this year? Y / N At which facility? _____	
What area are we treating today? (ex. back, knee, elbow, etc.):	Date of Injury/Day Symptoms Began?
Accident Related: Y / N Accident Type (circle one): Home Work Auto State of Accident: _____	
Referring Doctor:	Date of Surgery, If applicable?
Primary Doctor:	

INSURANCE INFORMATION*If patient is **NOT** the policyholder, please complete the information below*

Primary Insurance:	
Subscriber Name:	Birth Date:
Subscriber Address (If different from patient's):	
Relationship to Patient:	
Secondary Insurance:	
Subscriber Name:	Birth Date:
Subscriber Address (If different from patient's):	
Relationship to Patient:	