PerformaX Physical Therapy

NEW PATIENT INFORMATION

Office Use Only
First Visit_____
D.O.I._____
DX_____
RX Date:_____
Dr.

Name _____ ___ _____ Age ____Birth Date _____
Address _____ Social Security # ___-___- _____
Apt/Suite _____ □ Male □ Female
City _____ State ____ Zip _____-_____ □ Single □ Married □ Divorced
□ Widow/Widower

Employer _____ *(check the preferred phone number)*
Address _____ □ Home ( ) _____ - _____
PO Box/Suite _____ □ Cell ( ) _____ - _____
City _____ State ____ Zip _____-_____ □ Work ( ) _____ - _____

Emergency Contact_____ Phone_____ Relation_____

Primary Insured □ Patient □ Spouse □ Parent □ Other _____*(relationship)*
Complete the information below if the insured is not the patient.
Name _____ ___ _____ Birth Date _____
Employer _____

Secondary Insured □ Patient □ Spouse □ Parent □ Other _____ *(relationship)*
Complete the information below if the insured is not the patient.
Name _____ ___ _____ Birth Date _____
Employer _____

Attendance: It is important to maintain the schedule for treatment that your physician and therapist assign. If you cannot make an appointment please give us 24 hour notice and we will reschedule your visit to assure the continuity of your care.

Assignment: The undersigned assigns all insurance benefits to be paid directly to Performax Physical Therapy for all services rendered. In the event my insurance company declines payment I understand that I will be responsible for those charges.

Release: The undersigned permits Performax Physical Therapy to provide information to their insurance company, third party payor, physician and to any health care facility I am referred.

Consent: The undersigned consents to rehabilitation and related medical services provided by Performax Physical Therapy.

Liability: The undersigned agrees that Performax Physical Therapy is not responsible for loss or damage of my personal valuables.

Patient Signature: _____ Date _____

Parent/Guardian: _____ Date _____
(if patient is under 18)