PT360°
Better Together
Employee Owned Physical Therapy Cooperative

Date:_____

Appt.:_____

PT Assigned:_____

Patient Information

Name: _____

DOB: _____ Gender: ____ SS#_____
Primary Address: _____
City/State/Zip_____
Telephone: **Home:** _____ **Cell:** _____ **Work**: _____

Secondary Address: _____
City/State/Zip_____

E-Mail: _____ Student: Yes ☐ No ☐
May we contact you regarding insurance or billing questions through email? Yes ☐ No ☐

Employer: _____

Diagnosis: _____ Side: R ☐ L ☐
Referring Physician: _____Date last seen: _____
Primary Physician: _____

Emergency Contact: _____Tel #_____

How did you hear about us?

☐ Social Media ☐ Family /Friend ☐ Doctor
☐ Synergy ☐ Radio
☐ Print Ad ☐ Other. Please specify: _____

Medical Insurance Information

Primary Insurance: _____

ID#_____Group#_____

Policy holder: _____DOB:_____

Secondary Insurance: _____

ID#_____Group#_____

Have you had any PT this year? _____ **If yes,** how many visits: _____

Have you had any in-home care this year? (Such as UVM Health Network, Home Health and Hospice (used to be VNA) or BAYADA_____
If yes, when were you discharged? _____

Have you had any chiropractic visits this year? _____
If yes, how many: _____

Worker's Comp/Motor Vehicle Accident **WE ONLY ACCEPT MEDPAY FROM YOUR PERSONAL MVA INSURANCE-NO THIRD PARTY/LIABILITY. If your Medpay is maxed, we will bill your personal commercial insurance**

Insurance Company: _____
Tel. #_____
Address: _____
Contact Adjuster/Case Manager: _____
ID#_____
Date of Injury: _____ In what State: _____