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

Insurance Company: ____

Tel. #__________________

Address: ____

Contact Adjuster/Case Manager: ______________________________

ID#___________________

Date of Injury: _________________________ In what State: _______________________