



Date \_\_\_\_\_  
Appt. \_\_\_\_\_  
PT Assigned \_\_\_\_\_

### Patient Information

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Marital Status** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Primary Address:** \_\_\_\_\_  
**City/State/Zip** \_\_\_\_\_

**Telephone: Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Secondary Address:** \_\_\_\_\_  
**City/State/Zip** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Student:** Y / N

May we contact you regarding insurance or billing questions through email? Y / N

**Employer:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **R** / **L**

**Referring Physician:** \_\_\_\_\_ **Date last seen:** \_\_\_\_\_

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

**Emergency Contact:** \_\_\_\_\_ **Tel #** \_\_\_\_\_

**How did you hear about us?**

- Friend
- Synergy
- Print Ad
- Family
- Radio
- Other. Please specify: \_\_\_\_\_
- Doctor
- TV



## 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 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: \_\_\_\_\_