South Whidbey Physical Therapy
& Sports Clinic

PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to the information provided.**

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Address: _____
Street City

_____ Email:_____
State Zip

Phone: Home ( ) _____ Work ( ) _____Cell ( ) _____

Preferred way to contact you: ☐Home ☐Work ☐Cell ☐ E-Mail

DOB: _____ SSN: _____ ☐ Married ☐Single ☐Widowed ☐Other

Referring Physician: _____ Primary Care Physician : _____

Emergency Contact _____ Phone: _____
Name/Relation

The above information pertains to the patient only.
If the patient is a minor please fill out the Responsible Party Information below, in addition to the Insurance Information.

RESPONSIBLE PARTY INFORMATION **Relationship to patient ☐Mother ☐Father ☐Other**

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

DOB: _____ SSN: _____ Employer: _____

INSURANCE INFORMATION **ARE YOU AWARE OF YOUR INSURANCE BENEFITS? ☐Yes ☐No**

Primary Insurance: _____ Insured Name: _____

Policy ID# _____ Policy Group # _____ **☐SEE COPY OF CARD**

Secondary Insurance: _____ Insured Name: _____

Policy ID# _____ Policy Group # _____ **☐SEE COPY OF CARD**

ACCIDENT INFORMATION: Was this injury the result of an accident or on the job injury? ☐Yes ☐No

Date of accident/injury: _____ ☐Motor Vehicle Accident ☐Work Related ☐Other

CLAIM #: *Adjuster/Claim Manager Name & #:*

To the best of my knowledge the above information is complete and accurate.

_____ _____
Signature of Patient or Responsible Party **Date**