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 State Zip

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

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

If you are not available at the time we try to call you, may we leave appointment information on voicemail? □ Yes □ No

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

Referring Physician: _____ Primary Care Physician : _____

Employer Name/Address: _____
Street City, State, Zip

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? □ Yes □ No

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

The following person(s) can inquire, discuss account, pick up records, etc., and take messages regarding my health information: (Please include any physicians, friends, or relatives you may allow to take part in caring for your health and health information)

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

HIPPA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from South Whidbey Physical Therapy & Sports Clinic and understand it completely.

CONSENT: By signing this form, I agree and give my consent for South Whidbey Physical Therapy & Sports Clinic to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ _____
Signature of Patient or Responsible Party Date