Garden Ridge Physical Therapy & Wellness Center, P.C.
Patient Information Form
(Please Print Legibly)

Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

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

Social Security #: _____ Sex: Male/Female Date of Birth: _____

Marital Status (circle one) Married Single Divorced

Employer Name: _____ Can we contact you at work? Yes No

How did you hear about us? (Circle one) Friend/family Newspaper Website Physician

E-mail address: _____

Name of referring physician for current condition: _____

Date of injury or date pain began: _____

Emergency Contact
Name: _____ Relationship: _____

Home phone: (_____) _____Work :(____) _____Cell: (____) _____

Responsible Party: (if patient is a minor)
Name: _____ Relationship: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone :(____) _____ Work phone: (____) _____ Cell: (____) _____

Insurance Information (circle one)
Medical Insurance Workers' Compensation Auto Insurance Out-of-pocket Other_____

Primary Insurance: _____
Member ID: _____
Name of policy holder: _____
Policy holder's date of birth: _____
Policy holder's relationship to patient: _____

Secondary Insurance: _____
Member ID: _____
Name of policy holder: _____
Policy holder's date of birth: _____
Policy holder's relationship to patient: _____