PATIENT INFORMATION

Last Name____________________________ First____________________________ M.I._____
Mailing Address________________________________ City____________________ ST____ Zip__________
Primary Phone #___________________Other (Work) #__________________ Other #__________________
Email Address____
Date of Birth_____/______ /_____ Social Security #______________________ Age______
Marital Status (Circle) Married Single Widow(er) Divorced Separated
Full Time Student (Circle) Yes No School Name____
Employer___________________________________ Employer's Phone #______________________________
Employer's Address_____________________________ City____________________ ST______ Zip__________

GAURANTOR/POLICY HOLDER INSURANCE INFORMATION

Last Name______________________________ First____________________________ M.I.______
Address________________________________ City_________________________ ST_______ Zip____________
Primary Phone #____________________ Work #______________________ Cell #________________________
Date of Birth _____/ _____ /_____ Social Security #____________________ Age _______
Marital Status (Circle) Married Single Widow(er) Divorced Separated
Employer____________________________________ Employer's Phone #_______________________________
Employer's Address_____________________________ City______________________ ST_____ Zip___________
Patient's Relationship to the Guarantor (Circle) Self Spouse Child Other____________________
Primary Insurance Company Name____________________________________
Policy Holder's Name_______________________________ Date of Birth_____/ ______ /_____
Policy #____ Group #_________________________
If Worker's Compensation Claim: Adjuster's Name________________________ Phone #__________________
Date of Injury___________
Secondary Insurance Company Name___________________________________
Policy Holder's Name________________________________ Date of Birth_____/ _____ /_____
Policy #____ Group #_________________________

AUTHORIZATIONS

***TO PROMOTE A SAFE ENVIRONMENT FOR ALL INVOLVED, CHILDREN ARE NOT PERMITTED IN THE TREATMENT AREA UNLESS THEY ARE BEING TREATED. PLEASE MAKE OTHER CHILD CARE ARRAGEMENTS PRIOR TO TREATMENT. ***

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records will be retained by Ground Works Physical Therapy, PLLC even if my healthcare provider(s) leave the practice.

As the party responsible for medical decision making for the child represented in this medical record, I hereby give my consent to Ground Works Physical Therapy, PLLC to render both emergency and non-emergency healthcare services both in and out of my physical presence.

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment/participates.

Signature of Patient/Legal Guardian___________________________________ Date______________________

Updated Signature____ Date_____________________

Updated Signature____ Date_____________________