Lucia Miller Pelvic Health Physical Therapy

Physical Therapy and Pilates

PATIENT INFORMATION

Patient Name: _____

Address: _____

City/State: _____ **Zip:** _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Preferred Contact Method: Home _____ Cell _____ Work _____ Email _____

Emergency Contact Name/Relationship: _____

Emergency Contact Phone Number: _____

Employer: _____

Date of Injury: _____ **Work Injury? Yes ____ No _____**

Diagnosis: _____ **Referring Physician:** _____

Surgery? Yes _____ No _____ Date of Surgery: _____

Will you bill your PPO? Yes __ No ___

Preferred means of invoice: Email _____ Hard Copy _____

Assignment and Release: I authorize the release of any medical information necessary to process any claims. Lucia Miller, PT, MA, may be asked to provide information to my insurance company to process any claims. I understand that I am responsible for submitting my own claims to my insurance carrier, and for my own bills.

SIGNED _____ **DATE** _____