



**PATIENT INFORMATION:**

Patient's Name (Last, First, MI): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone ( cell or  work): \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Social Security Number: \_\_\_\_\_

If a patient is a minor Parent/Guardian name: \_\_\_\_\_ Phone: \_\_\_\_\_

Student Status:  High School  College  other \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

In case of an emergency who should be notified? \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Alternate Phone: ( cell or  work) \_\_\_\_\_

Please list any MEDICATIONS you are currently taking, prescribed or over the counter.  
Use the back of the page to add more if needed.

MEDICATIONS	DOSAGE	FREQUENCY

**ASSIGNMENT OF BENEFITS:**

I authorize my insurance company to pay benefits directly to Schwartz Physical Therapy for services rendered, instead of issuing payment to me.

Signature of Patient (minor's parent/guardian must sign) \_\_\_\_\_ Date \_\_\_\_\_

**I HEREBY STATE THAT THE INJURY WHICH I AM RECEIVING TREATMENT FOR IS NOT DUE TO A WORKMAN'S COMPENSATION CASE OR NO FAULT ACCIDENT.**

Signature of Patient (minor's parent/guardian must sign) \_\_\_\_\_ Date \_\_\_\_\_

**IT IS THE PATIENTS RESPONSIBILITY TO INFORM US IF YOUR INSURANCE CARRIER CHANGES DURING YOUR TREATMENT HERE. IF YOU FAIL TO INFORM US YOU WILL BE HELD RESPONSIBLE FOR ALL CHARGES NOT COVERED.**

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_