ELITE
SPINE & EXTREMITY
PHYSICAL THERAPY

Patient Information:

Last Name: ______________________________ First Name: _________________________
Sex: ________ Date of Birth: ___________________SS#: ________-_________-________
Address: ___________________________________ City: ____________________________
State: ______ Zip Code: ______________ Home#: ( ) _________-____________
Email: ____ Mobile#: ( ) ________-________
Marital Status: (circle) Single, Married, Divorced, Widowed, Domestic Partner

Employer's Name: _______________________________ Occupation: _________________
Physician's Name: ______________________________ Diagnosis: ___________________
Injury: Work or Auto related? _________ Allergies or Medical Precautions: ____________
Emergency Contact: ___________________________ Phone#: ( ) _________-__________

Insurance Information: *Office Only. Please verify if filled out.*

Insurance Co. Name: ____
Policy#:______________________ Address: _______________________________
City: _________________State: _____ Zip Code: _________
Insured's Name: _____________________________ SS#:______-_____-_______
Date of Birth: ___________ Address: ___________________________________
City: ___________________. State: _______. Zip Code: ______________________
Insured's Employer's Name:____

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a $20.00 fee will be charged for the missed session. (Please note that it is your responsibility- Insurance companies do not reimburse for missed appointments.

Patient's signature: ___________________________________
Date Signed: _______________