HUNTINGTON PHYSICAL THERAPY • PATIENT INFO SHEET

Patients Full Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Place of Employment: _____ Work Number: ( )_ _____
Phone Number: ( )_____ Date of Birth:_____
Sex: M F Marital Status: _____ S.S.# _____
Insured's Name:_____
Relationship to Patient: _____
Insured's Address: _____
City: _____ State: _____ Zip: _____
Phone Number: ( )_____ Work Number: ( )_____
Date of Birth: _____ Sex: M F S.S.#_____
Employer_____ Employer's Address:_____
Employer's Town: _____ State: _____ Zip: _____
Employer's Telephone #: _____

Referring Doctor: _____**Primary Doctor:** _____
Primary Insurance: _____ **Secondary Insurance**: _____

No Fault only:
Policy Holder: _____ Date of Accident: _____
Policy #_____ File # _____
Insurance: _____ Insurance address: _____
_____
_
Claims representative: _____ Ph#:_____
Dates missed from work: _____

Worker's Comp only: Case#_____ Carrier Case# _____
Address where injury occurred: _____
Date of injury: _____ Did you miss work? Y N
Have you returned to work? Y N Dates missed: _____

In Case of Emergency: _____ Phone #: ( ) _____
How did you hear of Huntington Physical Therapy? _____
_____
_

I authorize the release of any medical or other information to process this claim. I also request payment of government or private benefits to myself or to the party who accepts assignment on this claim.

Signature of Responsible Party: _____
Date: _____
I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Signature: _____
_____**Date:** _____