Date: _____

Name: _____

Birthday: _____/_____/_____ Age: _____ Sex: M / F

SS#:_____

Address:_____

_____

City: _____

State, Zip Code: _____

Phones: (Home) _____ (Cell) _____

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Elm Grove Physical Therapy, Inc.
a division of Maria Zanoni Physical Therapy, Inc.

Health Insurance Information: *(Please present your insurance card for copy)*

Insurance Co.: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber ID: _____ Group: _____

Relationship to patient: _____

Subscriber Information: *(if other than patient)*

Address: _____ Phone #: _____

City, State, Zip: _____

Employer: _____ Work #: _____

★★★★★★★★★★

GUARANTOR:
Please complete if person responsible for bills is not the patient or patient is a minor.

Name: _____ Relationship to patient: _____

Address: _____ Phone #: _____

City, State, Zip: _____ Cell #: _____

★★★★★★★★★★

Present Symptoms:

_____

_____

Who referred you? _____

Name of Referring Physician: _____ *(if applicable)*

Date of Injury: _____ ☐Auto ☐ Work ☐ Sports ☐ Other

Health Information:

Medical History (surgeries, hospitalizations, major falls, etc.):

_____

_____

_____

_____

Medications (with dosage if known):

_____

_____

Allergies:

_____

_____

☐ I DO NOT HAVE OR WISH NOT TO BILL ANY MEDICAL INSURANCE / HEALTH INSURANCE PLAN.
I understand that payment is due at the time service is rendered, unless other arrangements are made prior to appointment.

The physical therapy services are provided by the independently owned business of Maria Zanoni, PT.
I authorize consent to treatment by Elm Grove Physical Therapy, Inc. for the named patient.

I authorize release of any and all information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating, administering care and administering claims for insurance benefits; and as required by State, local and federal law. I realize that I am responsible for all charges incurred.

_____

Signature of patient (or parent if minor) Date

I acknowledge that I have received: NOTICE OF PRIVACY PRACTICES from Elm Grove Physical Therapy, Inc.

_____

Signature of patient (or parent if minor) Date

We appreciate a 24-hour notice of cancellation. In the event of a late cancel or a no-show, you will be charged $50. This cannot be billed to your insurance company and will be your responsibility.

_____

Signature of patient (or parent if minor) Date