Ocean Shores Physical Therapy Services

Patient Information

Last Name____________________________________First Name___________________________MI________

Mailing Address____Zip__________________

Home Phone _________________________Cell________________________Work______________________

Date of Birth ___________________SSN ______________________Gender _______Marital Status_________

Emergency Contact_______________________Relationship_______________Phone_____________________

Referred By_______________________________Primary Care Physician______________________________

Are you receiving any Home Health services?	**Yes**	**No**
Have you had any Physical Therapy this year?	**Yes**	**No**
Is this injury related to a Motor Vehicle Accident?	**Yes**	**No**
Is the reason for your visit due to a Work-Related Injury?	**Yes**	**No**

Worker's Compensation Insurance Company ____

Claim # ______________ Claim Manager ____________________ Phone # ______________________

Primary Insurance Plan________________________ID________________________Group______________

Subscriber___________________________Relationship________________ Date of Birth_________________

Secondary Insurance Plan______________________ID________________________Group______________

Subscriber___________________________Relationship________________ Date of Birth_________________

I give my consent and authorization to Ocean Shores Therapy Services to treat my condition. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I acknowledge I must notify Ocean Shores Therapy Services immediately to any changes regarding my health insurance plan or coverage. I authorize the release of all information necessary to secure the payment of insurance benefits.

Signature of Patient/Guardian____________________________________ Date_______________________