Charlestown Physical Therapy and Health Services LLC

3939 Old Post Rd. Charlestown, RI 02813 401-364-2020

Demographic and Insurance information

Name		Nickname	Date of Birth	
Street Address		City/Town	State	Zip code
Mailing Address (if different)		City/Town	State	Zip code
Are you a seasonal resident? (please circle) Yes No		Social Security Number (for billing purposes)		
Home Phone	Cell Phone	E-mail (May we contact you with event info) Y N		
Marital Status ☐Married/ Partnership ☐Single ☐Divorced/Separated ☐Widowed		Employment Status ☐Full Time ☐Student ☐None ☐Part Time ☐Retired ☐Out due to injury		
Emergency Contact Name		Phone Number	Relationship	
Referring Physician		Primary Care Physician	Date of Last Physical	
Insurance Carrier		Insured's Name (if different from patient)	Date of Birth	
ID Number	Phone Number (if applicable)	Adjuster's Name (if applicable)		
Employer (at time of injury)		Job Title/Position		
Has Your Deductible Been Met ☐Met ☐Not Met ☐Partially Met ☐Unsure/NA		Co-Pay/Co-Insurance Amount $______ _____% ☐None ☐Unsure		
Is this injury related to a legal case? YES NO	Lawyer's name (if applicable)	Will you or have you filed for disability? YES NO		
How did you hear about Charlestown Physical Therapy?				
Describe the Current Injury (including date of injury or approximate onset of symptoms)				

I attest that the above information is accurate and complete to the best of my knowledge.

Patient Signature (Parent or Guardian's Signature if under 18) Date