# PATIENT INFORMATION

Date: _____

(Last) _____ (First) _____ (MI) _____

_____ Male _____ Female DOB: _____ Age: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Work # _____ Cell # _____

Employer: _____ Occupation: _____

Referring Doctor: _____ Family Doctor: _____

How did you hear about our clinic? _____

**Spouse's Information**

Name: _____ DOB: _____

Employer: _____ Occupation: _____ Contact #: _____

**Emergency Contact Not Living With Patient**

Emergency Contact: _____ Contact #: _____

**Complete if Patient is a Minor**

Father/Guardian: _____ DOB: _____

Cell #: _____ Work #: _____

Mother/Guardian: _____ DOB: _____

Cell #: _____ Work #: _____

**RELEASE OF BENEFITS AND INFORMATION OF CONSENT TO TREATMENT:** I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to U-District PT all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I consent to treatment by the authorized personnel of U-District Physical Therapy as may be dictated by prudent medical practice by illness, injury, or condition. This consent is intends as a waiver of liability for such treatment except in acts of negligence.

Signed: _____ Date: _____

(Parent or Guardian if patient is a minor)