Joints In Motion Physical Therapy

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____City:_____ State:_____ Zip:_____

SS#:_____ DOB:_____ Email:_____

Home Phone:_____ Cell Phone:_____Sex: M F

Employer:_____Position:_____

Address:_____ Work Phone:_____

Marital Status: S M W D Spouse:_____

Spouse's Employer:_____ Postition:_____

Address:_____Work Phone:_____

**********Emergency Contact**********

Parent/Guardian Spouse Other_____Name:_____

Address:_____Phone:_____

**********Insurance Information**********

Private Workers Comp MVA State of MVA:_____Other:_____

DOI/DOS:_____Company:_____

Insured:_____SS#:_____ DOB: _____

ID#_____ Group#:_____

Claims sent to:_____

**********Authorization & Release**********

I herby authorize the release of any information concerning my treatment provided for the purpose of communicating with other healthcare workers invovled in my care or for evaluating and administering claims for insurace benefits. I also authorize payment of insurance benefits otherwise payable to me to be applied directly to *Joints In Motion Physical Therapy.*

Signature of Patient/Guardian **Date**