Patient Information

Patient Name _____Male ___ Female__

□ Married □ Divorced □ Widowed □ Single

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ S.S. Number_____

Date of Birth _____ Age _____ Primary Insured's Date of Birth _____

Employer _____ Employer Phone _____ Occupation _____

Date of Injury _____ Date of Surgery _____ **Email** _____

How did you hear about us? (check all that apply)

□ Physician Directed Me □ Physician Let Me Choose □ Radio □ Sign □ Family/Friend

□Yellow Pages □ Location □ Referred Myself □ Other_____

Referring Physicians Name _____

Is there another physician you would like us to keep updated? _____

Insurance Information

I hereby consent to such physical therapy and occupational therapy procedures as may be rendered by Physical Therapy of Idaho. There is also consent for authorization for all insurance benefits to be paid directly to Physical Therapy of Idaho, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage.

Patient Signature _____ Date _____

(Parent signature if 18 or under)

Medicare and Medicaid Patient Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Physical Therapy of Idaho for any service furnished me by Physical Therapy of Idaho. I authorize any holder of medial information about me to release to the Centers of Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine there benefits or the benefits payable for related services.

Patient Signature: _____ Date _____