## Personal Information

Patient's Name: ________________________________________ Date: _____________________

Street Address: ____________________________________________________________________

City: _______________________________ State: _______________ Zip: ________________

Home Phone: _______________ Work Phone: ________________ Cell Phone: _______________

Social Security Number: _______________ Marital Status: __________ Date of Birth: ___________

E-Mail Address: __________________ ( E-mail is to be used for communication with Parry PT only)

## Emergency Information

Person to Contact in the Event of an Emergency: __________________ Phone Number: ____________

## Employment Information

Place of Employment: ________________________________ How Long: ____________________

Occupational Title: _________________________________________________________________

Are you currently working? ____________________ If no, date last worked: __________________

Employer Address: __________________________________________________________________

## Physician Information

Name of Referring Physician: _________________________________________________________

Name of Primary Care/General Physician: ________________ Phone Number: __________________

## Insurance Information

Name of Insurance Company / Workers Compensation Carrier: ________________________________

Address: __________________________________________________________________________

Name of Insured as Shown on Policy: ___________________________________________________

Policy #: __________ Claim #: ____________ ID #: _____________ Group #: ________________

## Attorney Information

Have you retained an attorney with regard to the above injury?___________________

Attorney's Name: __________________________ Phone Number: ___________________________

Attorney's Address: _________________________________________________________________

I hereby authorize Parry Physical Therapy & Athletic Enhancement to bill my insurance company on my behalf, and I direct that payment for treatment rendered be provided directly to Parry Physical Therapy & Athletic Enhancement. I understand that Parry Physical Therapy & Athletic Enhancement, Inc. is not party to my agreement with my insurance carrier and that I am solely responsible for the payment of any charges incurred at this facility. I understand that charges for services provided are due and payable prior to treatment.

Patient's Signature: ________________________________________ Date: __________________

(or signature of *Parent or Guardian if Patient is a minor)*