Paso Robles Physical Therapy
One-on-one personal care for exceptional results.

Patient Information Form

Today's Date: _____

Patient Demographic Information			
***Last Name**	***First Name**		***Middle Initial**
Address	City	State	Zip Code
***Home Phone**	***Appointment Reminder Contact Method** ☐Text ☐Mobile ☐Email ☐Home Phone (Choose method of choice) ☐No Appointment Reminder		
***Mobile Phone**	***Email Address** ☐Declined Email ☐No Email		
***Date of Birth**	**Pediatric Patient** Parent/ Guardian Name	***Sex** ☐F ☐M	Status ☐Single ☐Married ☐Other

Employer Information			
Employer	Employment Status ☐ FT ☐PT ☐None ☐Retired ☐Student		
Address	City	State	Zip Code
Work Phone	Occupation		

Emergency Contact Information		
Contact Name	Phone	Relationship

Physician Information		
Referring Physician	Phone	Script Date

Additional Questions			
Injury /Onset Date	Post-Surgical ☐Yes ☐No	Surgery Date	Body Part/DX
Work Related ☐Yes ☐No	Accident Related ☐Yes ☐No	Auto Related ☐Yes ☐No	Attorney Involved ☐Yes ☐No
Adjuster/Nurse Cases Mgr.	Phone	Attorney	Phone
Have you had prior Therapy thisyear? (PT/OT/SP/Chiro) ☐Yes ☐No		How did you hear about us?	

Medicare ONLY! Additional Questions	
If Medicare, are you currently Receiving HomeHealth Services? ☐Yes ☐No	
If YES, Name of Agency	If discharged what is last date of service?
Are you currently residing in a Skilled Nursing Facility? If Yes, Name of facility	

Primary Insurance Section		Secondary Insurance Section	
***Insurance/Plan**		***Insurance/Plan**	
***Policy ID #**		***Policy ID #**	
***Group #**		***Group #**	
***Insurance Phone**		***Insurance Phone**	
Are you the policy holder? ☐Yes ☐No If no, continue		Are you the policy holder? ☐Yes ☐No If no, continue	
Card Holder Name	DOB	Card Holder Name	DOB
Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child		Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child	
Patient, Please initial here if the above information is correct and complete		Date	

Office Staff use ONLY (below)		
Intake Completed by	Date	***Date Eval Scheduled**
Physical Therapist	Date	Diagnosis Code
Eligibility and Benefits Confirmed ___ Number of visits per year _____ Deductible _____ Deductible Met ___ Co-insurance/ Co-pay _____		
Patient Initialed and Signed Financial Agreement ___	Authorization Required? ___ Insurance Cards Copied ___	Chart Completed ___ Imaging Reports Received ___ Medication List Recieved ___