LANCASTER PHYSICAL THERAPY & SPORTS MEDICINE

Name: ___________________________________. **Sex:**_____ **Male** _____ **Female**
(first, middle initial, last)
Address: ____**City:** ______________________________ .
State: _________________________. **Zip:**________________.

E-Mail Address: _______________________________________
S.S. # _________- _________- _______________. **D.O.B.** ___________________________.
Home/Contact Phone: (_____)- ______- __________. **Cell Phone:** (_____)- ______- __________.

Diagnosis: _______________________________. **Date of Onset/ Injury:** _______________________.

Surgery (related to diagnosis), if any--- Type and Date____

Additional Information:

Referring Physician: __________________________. **Family Physician:**______________________.
Patient's Employer:____________________________. **Employer Phone:** _______________________.

If NO employer, check below:
_____Student, _______Disabled, ________Retired, _______Unemployed

**<u>Since January 1 of this year, have you had any….</u>

PHYSICAL THERAPY? NO or YES*
OCCUPATIONAL THERAPY? NO or YES*
SPEECH THERAPY? NO or YES*
CHIROPRACTIC CARE? NO or YES*

Auto Related? Yes or No
WC Related: Yes or No
If WC, employer's name__________________________

***ANY OF THESE THERAPIES MAY COUNT TOWARDS YOUR AUTHORIZATION OR VISIT LIMIT**
*** If YES to any above. How many visits?**______________

How did you hear about Lancaster PT?
- Dr. ______________________
- Advertisement/Yellow Pages
- Other ____________________
- Friend

HIPPA: Other than what is mentioned on the Patient Consent Form, please list any names you give us permission to release or disclose health information:

____

Emergency Contact Name and Phone #:
(in case something were to happen to you here):
____.

Insurance Information:

Primary Insurance: **Secondary Insurance:** **Third Insurance:**

<u>Policy Holder Information</u>

Is this for 1st, 2nd or 3rd Insurance?
Name:__________________________ Address (if different):_____________________________.
Phone: (_____)- ______- __________. D.O.B. _________/ ___________ / __________.
Employer:__________________________Relationship to Patient:_____________________________.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lancaster Physical Therapy & Sports Medicine to release any information required to process my claims.
*Patient/Guardian Signature:*_____________________________________*Date:*_____________________.