



Personalized manual therapy to end your pain and restore your quality of life.

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: ___/___/___

Patient's Address (No., Street): _____

City/State/Zip: _____

Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Place of Work: _____ Work Phone: _____

Email Address: _____

We request your email address in order to provide you with important medical information on a timely basis.

We assure you that we will NOT share your email address with any third party.

Referring Physician: _____

Primary Care Physician: _____

Secondary Residence (If applicable): _____

City/State/Zip: _____

Home Phone: _____ Cell Phone #: _____

In case of an emergency, who may we contact? _____

Relationship to patient: _____ Home Phone: _____ Work Phone: _____

Contact's Address (No., Street): _____

City/State/Zip: _____

Are you currently seeing a chiropractor? Y N

Have you received physical therapy since January 1, 2009? Y N

Are you currently receiving home health care? Y N

Reason for previous physical therapy: _____

How did you hear about us? _____

INSURANCE INFORMATION

Insurance Plan Name: _____ ID Number: _____

Policy Group Number: _____

Name of Insured: _____

Address of Insured: _____

I authorize the release of the above information for treatment, payment, health care operations, and to process insurance claims. I also understand that I am responsible for charges if my insurance company fails to pay for services rendered. I consent to treatment by AIM Physical Therapy, PA.

Signature: _____ Date: _____