HOWARD COUNTY PHYSICAL THERAPY

Patient Demographic Sheet

Date: ______________________________

Patient Name: ____ Gender: Female / Male

Address: ____

City: ____ State: ______________________ Zip: _______________________

Home Phone: ____ Work Phone: ____

Cell Phone: _______________________________________ E-Mail: ____

Date of Birth: ______________________________ Age: _______________ Soc.Sec.#: ____

Employment Status: Full-Time / Part-Time / Retired / Student / Self-Employed / Disabled

Occupation: ______________________________________ Employer: ____

Employer Address: ____

Marital Status: Single / Married / Separate / Divorced / Widowed

Spouse's Name (or Parent's Name if Minor): ____

Spouse/Parent Employed By: ______________________________________ Work Phone #: ____________________________

In case of emergency, please contact:

Name: _____________________________ Phone #: ________________________________ Relationship: _____________________

How did you hear about Howard County PT? ____

Referring Physician: ____ Phone: ____

Primary Care Physician: ____ Phone: ____________________________________

Describe reason for visit: ____

____

____

Date of Onset/Symptoms/Surgery: ____

Tests or Procedures Performed (X-Rays, EMG, CT Scan, ETC.): ____

CONTINUED ON BACK

Previous Treatment:

Previous Physical Therapy Services? Yes / No   Previous Chiropractic Services? Yes / No

Previous Speech Therapy Services? Yes / No   Home care services? Yes / No

What body area was treated? ___________________________When?_____________________

Where was treatment rendered? ____

Insurance Information

Health Insurance (Primary – Insurance Filed First):

Company Name: ___________________ Policy #: ________________________ Group #: ______________

Policy Holder Name:____ DOB: _____________________

Relation to patient: Self Spouse Parent

Health Insurance (Secondary – Insurance Filed Second):

Company Name: ____________________Policy #: _______________________ Group #: ______________

Policy Holder Name:____ DOB: _____________________

Relation to patient: Self Spouse Parent

Is this the result of an auto accident: Yes / No   Worker's Compensation: Yes / No

Other Accident: Yes / No

If other, please explain: ____

Date of accident: ____

If work accident, name of employer: ____

Employer's Address: ____

If auto accident, name of car owner: ____

Insurance Company: ________________________________ Claim Number: _________________________

Address: ____ City, State, Zip: _______________________

Claim Adjuster: _______________________________________ Phone Number: _________________________

Attorney: ____ Phone Number: _________________________

Address: ____ City, State, Zip: _______________________

Have you submitted any claims to PIP, including lost wages Yes / No   Lost time from work due to accident Yes / No

Dollar Amount of PIP Available**: ____

****IF YOU DO NOT KNOW THE AMOUNT OF PIP AVAILABLE, PLEASE CONTACT YOUR INSURANCE COMPANY****