

MADY AND MULES 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 Mady and Mules? _____

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****