Advanced Physicians
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PATIENT INFORMATION AND AUTHORIZATION FORM

Acct. #:________________

Please fill in this form and bring with you to your first appointment. Thank you!

Today's Date________________ Social Security Number:____________________________

First Name__________________________________ Last Name_______________________________________

Birth Date________________________ ex: ❑ Male ❑ Female

Home Address____

City/State/ Zip____

Home Phone_________________ Cell Phone:_______________ Email:_____________________________________

How do you prefer to receive appointment reminders? ❑Email ❑Cell Phone ❑Home Phone

Insurance Carrier: ______________________________ Subscriber ID: __________________________________

Do you have secondary insurance ? ❑ Yes ❑ No

If yes, please provide secondary insurance information ____

Referring doctor/Friend ____________________________ ❑ A friend referred me ❑ Self Referral Emergency

Emergency Contact - Name, Phone, Relation:

____

Reason/Diagnosis Requiring Treatment:

____

Have you ever received PT or OT for this condition before? ❑Yes ❑No

No Pain--Severe Pain

What is your current pain level today when at rest: 0 1 2 3 4 5 6 7 8 9 10

No Pain--Severe Pain

What is your current pain level today when at rest: 0 1 2 3 4 5 6 7 8 9 10

Primary Care Physician/Address:____

By signing below, I consent to receiving physical therapy evaluation and treatment:

Patient Signature (Parent if under 18 years old) ____

Date Signed ___________________________