PATIENT INFORMATION

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Email Address: _____ Cell Phone ( ) _____

Home Telephone ( ) _____ Work Telephone: ( ) _____

Date of Birth _____

Physician: _____ Ailment: _____

Responsible Party Information (Primary Insured)

Relationship to Patient: ( )Self ( )Spouse ( )Parent ( ) Other

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Email Address: _____ Cell Phone ( ) _____

Home Telephone ( ) _____ Work Telephone: ( ) _____

Date of Birth _____

Employer Information

Employer Name: _____

Job Title: _____

I authorize Focus Physical Therapy to release any medical or other information acquired during my Examination and/or treatment to any insurance company, employer, hospital or physician should they require a report. I assign/authorize payment of medical benefits to Focus Physical Therapy for all services rendered. authorize Focus Physical Therapy to render physical therapy services.

_____ _____ _____

Patient/ Responsible Party **Relationship** **Date**