SET SPORTS PHYSICAL THERAPY

Patient Information Record

Patient's Name ______________________________ Date ____________
(first) (middle) (last)

Address ______________________________ City __________ State _____ Zip ______

Home Phone ____________ Work Phone ______________ Mobile Phone ______________

Date of Birth ________________ Age ______ Social Security Number _____ - _____ - _____

Email Address ____________________________ Sex ☐ M ☐ F Marital Status ☐ S ☐ M

Referring Physician ________________________ Date of Injury ____________________

Employer's Name ______________ Occupation _____________ Phone # ______________

Emergency Contact ____________________________ Contact Phone # ______________

Insurance Information

Primary Insurance Company/Type _______________________ Effective Date ____________

Subscriber ID Number _________________ Group Number ____________ Plan Code ________

Insured Name (if different from patient) ____________________ Insured SSN _____ - ____ - _____

Insured Date of Birth __________ Insured Address __________________________________

Billing Information

Type of Credit Card ☐ Visa ☐ MC ☐ Amex Name (if different from above) ________________

Billing Address (if different from above) ____

** For Office Use Only **

Deductible ____________ Deductible Met? _____________ Out of Pocket Met? __________

Effective Date ____________ Approved Visits/max _____________ Co-insurance (%) ________

Claims Address ____

Insurance Phone _____________ Number Fax Number _____________ Payer ID# __________

Physician Information

Referring Physician ______________________ Specialty ____________ NPI ____________

Address ____

Phone Number __________ Fax Number _____________ Prescription Date ____________