



PATIENT INFORMATION

NAME: _____

DOB: _____

SSN: _____

GUARDIAN NAME: _____

MARITAL STATUS: SINGLE MARRIED

MINOR DIVORCED WIDOWED

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

BILLING ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

EMAIL: _____

EMPLOYMENT / SCHOOL: _____

SPOUSE'S EMPLOYER: _____

HOME PHONE: () _____

CELL PHONE: () _____

IN CASE OF EMERGENCY CONTACT

NAME: _____

RELATIONSHIP: _____

HOME PHONE: () _____

CELL PHONE: () _____

HOW DID YOU HEAR ABOUT OUR FACILITY: _____

ACCIDENT INFORMATION

CURRENT CONDITION DUE TO ACCIDENT: YES / NO

DATE OF INJURY: _____

TYPE OF ACCIDENT: AUTO WORK

HOME OTHER

TO WHOM DID YOU REPORT THE ACCIDENT TO:

EMPLOYER AUTO INSURANCE

WORKER COMP OTHER

ATTORNEY NAME: _____

ATTORNEY PHONE: () _____

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

RELATIONSHIP TO PATIENT: _____

INSURANCE CO.: _____

SUBSCRIBER #: _____

GROUP #: _____

IS PATIENT COVERED BY ADDITIONAL/ SECONDARY

INSURANCE: YES NO

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

RELATIONSHIP TO PATIENT: _____

INSURANCE CO.: _____

SUBSCRIBER #: _____

GROUP #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant (s), have health insurance coverage with (Insurance co. Name)

_____ and assign directly to MDR Physical Therapy Inc., dba AGILITY Spine & Sports Physical Therapy, insurance benefits, if any, otherwise payable to me for services needed. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that I am responsible for my co-payments / co-insurance, which is due at time of treatment, and any applicable deductible that has not been met. I authorize the use of my signature on all insurance forms. The above named facility (including its' employees) may use my treatment care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of payment for services and determining insurance benefits or the benefits payable for related services.

(SIGNATURE OF PATIENT / LEGAL GUARDIAN)

(PLEASE PRINT PATIENT NAME)

(TODAY'S DATE)

(GUARDIAN NAME)