Northwest Physical Therapy Clinic

Patient Information Sheet

Patient Information

Patient Name: _____
(First) (M.I.) (Last)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ SS#: _____ Circle One: Male or Female

Student: Y or N Full Time or Part Time Marital Status □ Single □ Married □ Divorced □ Widowed

Employer: _____ Work Phone: _____

Employer Address: _____
City State Zip

Occupation: _____ Physician Referral: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Alternate Phone: _____

Insurance Information

Primary Insurance Carrier: _____ Address: _____

ID#: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS#: _____

Relationship to Patient: □ Self □ Spouse □ Mother □ Father

Secondary Insurance Carrier: _____ Address: _____

ID#: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS#: _____

Relationship to Patient: □ Self □ Spouse □ Mother □ Father

Patient Signature: _____ Date: _____

If patient is a minor or requires guardianship, Parent or Guardian must sign below:

Parent/Guardian Signature: _____ Date: _____

Northwest Physical Therapy Clinic

Accidental Injury Questionnaire

Is this Physical Therapy care the result of an accidental injury? □ Yes □No

****If your answer is no, please sign below **If your answer is yes, please fill out the following****

Date of Accident: _____ Time: _____ Location: _____

Motor Vehicle Accident Information

Policyholder Name: _____ Policy #: _____

Auto Insurance Name: _____ Phone: _____

Agents Name: _____ Claim #: _____

Do you carry Personal Injury Protection and/or MedPay? □ Yes □ No Limit $ _____

Do you carry Uninsured Motorist? □ Yes □ No Limit $ _____

If your accident involves a third party, please complete the following

Name and Address of 3rd Party: _____

Name and Address of 3rd Party Insurance Carrier: _____

Adjuster Name: _____ Phone: _____ Claim#: _____

Name of your Attorney: _____ Phone: _____

Workers Compensation Information

Name and Address of your Employer: _____

_____ Phone: _____

Name and Address of your Employers Workers Compensation Carrier: _____

_____ Phone: _____

Workers Comp. Claim or Case #: _____

Case Nurse Manager Name: _____ Phone: _____

If your Workers Compensation claim has been denied, attach a copy of the denial

If condition was related to a Motor Vehicle Accident, Workers Compensation, or Third Party, Please sign below:
These answers are true and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

If patient is a minor or requires guardianship, Parent or Guardian must sign below:

Parent/Guardian Signature: Date:

Sign below if condition was NOT cause by an accident:
Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____