RIVERA
PHYSICAL THERAPY

Patient Information

Date _____

Appointment Date/Time _____

Diagnosis: _____’

Referring Physician: _____

Primary Physician: _____

Patient’s Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible person: _____
(Name, address, phone - for patient’s under the age of 18)

Emergency Contact: _____
(Name, address and phone)

_____

Employer Information:

Name: _____ Phone: _____

Address: _____

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Insurance Information

Please give rections your insurance card(s)

Worker Compensation:

Rehab Nurse: _____
Date of injury: _____
Clain number: _____
Insurance company address: _____

MVA /Auto:

Date of injury: _____
Clain number: _____
Insurance company address: _____

Have you had physical/occupational therapy or chiropractic care in the past year? Y N
If Yes, please state where: _____

Have you received physical/occupational therapy for this diagnosis before? Y N
If Yes, please state when: _____

CONSENT RELEASE AND ASSIGNMENT:

I hereby authorize Rivera Physical Therapy, P.C to furnish medical information to my Insurance carrier concerning this Injury and treatment. I assign my insurance benefits to be paid directly to Rivera Physical Therapy, P.C. I understand that I am financially responsible for non-covered services, deductibles, co-pays and co-insurances due to Rivera Physical Therapy, P.C. I hereby authorize the Physical Therapist or Assistant to render treatment and procedures in my care.

_____

Patient/Guardian Signature Date