IMPACT PHYSICAL THERAPY

Patient Information PLEASE COMPLETE ALL SECTIONS				
Last Name:	*First Name:*	*MI:*	*Sex:*	*Birth Date:*
Address:	*City:*		*State:*	*Zip Code:*
Email:	*Social Security Number:*			
Marital Status: *S M D W*	*Home Number:*		*Cell Number:*	
Emergency Contact:	*Phone Number:*		*Relationship:*	

Personal Insurance		
Insurance Co. Name:		
Insured's Name:	*Insured's Social Security Number:*	*Insured's Birth Date:*

Workers Compensation/Motor Vehicle Accident			
Insurance Co. Name:		*Phone Number:*	
Billing Address:		*City:*	*State:* *Zip:*
Claim Number:	*Employer Name:*	*Employer Address:* *Phone Number:*	
Contact Agent Name:		*Contact Agent Phone Number:* *Fax Number:*	
Date of Accident/Injury:		*Place of Accident/Injury:*	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Therapist. I understand that I am financially responsible for any balance and also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits by my insurance company and policy. I also authorize Impact Physical Therapy or insurance company to release any information required to process my claims.

Signature:	Date:
Parent or guardian (if minor):	Date: