FOOTHILLS PHYSICAL THERAPY

PATIENT HISTORY

Date: ______________

Name: ______________________________ DOB: ______________

Address: ______________________________ SS#: ______________

City: ______________________________ State: __________ Zip: __________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Employer ______________________________ Email Address: ______________________________

Emergency Contact: ______________ Relationship: __________ Phone: __________

Have you previously had physical therapy? Yes No When? ______________

Are you currently receiving any type of VNA Services? Yes No

Was it for the same problem that you are currently seeking treatment? Yes No

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Primary Physician: ______________________________ Phone: ______________

Referring Physician: ______________________________ Phone: ______________

How did you hear about us? ______________________________

PLEASE COMPLETE: Name of Insurance to Bill: ______________________________

Address: ______________ City: __________ State: ________ Zip: ________

ID/Claim#: ______________________________ Group #: ______________

Health Insurance Subscriber: (circle one) Self Spouse Parent

If other than self: Name: ______________________ DOB: ______________

If Injury is related to work or an auto accident - DATE OF INJURY______________

PLEASE CIRCLE if applicable: AUTO: YES/NO State of accident______ **WORKERS COMP**: YES/NO

Adjuster: ______________________________ Phone #: ______________________________

PRIVACY NOTICE

We here at Foothills Physical Therapy feel that your privacy should be protected. In the course of your treatment, we collect person information about you that is necessary to treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access and/or have a copy of this information.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Foothills Physical Therapy.

Signature of Patient or Guardian______________________________ Date______________

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www.foothillsphysicaltherapy.com