

PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**



South Lane Physical Therapy^{LLC}

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () _____ WORK () _____ CELL () _____

EMAIL: _____ PREFERRED WAY TO CONTACT YOU: HOME WORK CELL SEX: MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
 MARRIED SINGLE WIDOWED SEPARATED OTHER

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMPLOYER NAME/ADDRESS: _____
STREET CITY, STATE ZIP

EMERGENCY CONTACT: _____ PHONE: _____
NAME/RELATION

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY.

IF THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION. IF THE PATIENT IS NOT A MINOR, THEN SKIP THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT MOTHER FATHER OTHER

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME () _____ WORK () _____ CELL () _____

EMPLOYER: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? YES NO

PRIMARY INSURANCE NAME: _____ INSURED NAME: _____

PRIMARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

SECONDARY INSURANCE NAME: _____ INSURED NAME: _____

SECONDARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

ACCIDENT INFORMATION: Was this injury the result of an accident? No Yes DATE OF ACCIDENT/INJURY: _____

MOTOR VEHICLE ACCIDENT WORK RELATED OTHER

HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from South Lane Physical Therapy, LLC and understand it completely.

CONSENT: By signing this form, I agree and give my consent for South Lane Physical Therapy Services, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Signature

Date