Healing Motion Physical Therapy

Patient Information Form

| Patient Name: | | Date of Birth: | Age: | _ |
|--|---|-------------------------------------|-------------------------------------|-------|
| Last | First | | (MM/DD/YYYY) | |
| | | | | |
| | r PO Box | City | State Zip | |
| Home Phone: | Cell Phone: | Work Phone | »: | - |
| E-Mail: | | Preferred Contact Method: | Text email home cell | |
| (Your E-Mail will not be used for any o | | | | |
| Date of Injury/Onset: | Had any Physica | al Therapy this year? : YES / | NO | |
| | Insurance In | <u>iformation</u> | | |
| Is Injury Workers Comp or Auto r | elated? Yes / No Case worker i | info | | _ |
| Primary Insurance Plan: | | | | |
| ID/Polic | :y#: | Group#: | | _ |
| Secondary Insurance Plan: | | | | |
| ID/Polic | :y#: | Group#: | | |
| | Emergency Conta | act Information | | |
| Name: | Phone: | Relationsh | ip to Patient: | |
| Who may we thank for referri | ng you? | | | |
| <u>Pat</u> | ient's Authorization to | Release Medical Reco | ords | |
| I authorize Healing Motio purpose of my physical ther | on Physical Therapy to <u>request</u> apy visit. | t <u>/send/release</u> medical reco | rds that are in relation to t | the |
| Signature Authorizing Rel | | nderstand there <u>may</u> be a f | Date Fee for this request of \$3 | 30.00 |
| | FOR OFFICE | USE ONLY | | |
| Appointment Date: Referring Physician: | | ☐ Nev | w Patient 🔲 Return Pati | ient |