

Longview Physical & Sports Therapy

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ SSN _____ Gender _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit _____
Referred By _____
Latest Referral Information _____ Motor Vehicle Accident _____
Latest Plan of Care _____ That occurred in: _____
Notes: _____

Primary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

Tertiary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	Coinsurance _____	Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the financial policy form.

I hereby acknowledge that I have been offered a copy of the LPSTS's Notice of Privacy Practices.

Signature: _____ Date: _____