RS PHYSICAL THERAPY

Patient Information

Name_____ Social Security #_____

Date of Birth_____ Sex: Male __Female__ Relationship to Subscriber_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____Email address_____

Referring Physician_____ Phone_____

Do you have Health insurance Yes No

Are you currently receiving Home Health Services? _____

Have you received Physical Therapy or Speech Therapy this year? **Yes No**

Primary Insurance Information:

Name of Insurance_____ ID #_____ Group#_____

Name of Subscriber_____ DOB_____SS#_____

Address of Subscriber_____ City____

State_____ Zip Code_____ Subscriber‘s Phone _____

Secondary Insurance Information:

Name of Insurance_____ ID #_____ Group#_____

Name of Subscriber_____ DOB_____SS#_____

Address of Subscriber_____ City____

State_____ Zip Code_____ Subscriber‘s Phone _____

Is this Workman’s Comp? Yes **No** Claim #_____

Name of Case Manager_____ Phone#_____

_____

Patient Signature Date

_____

Legal Representative/Parent/Guardian Date

9/15