

**Patient Information**

First Name: Last Name: MI: DOB:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email: Gender:  Male  Female SSN: / /

**Emergency Contact**

Name: Relationship: Phone Number:

**Employer/school**

Name: Phone:

Address: City: State: Zip:

**Insurance Information**

Worker’s Comp  Date of Injury: Motor Vehicle Accident  Date of Injury:

Adjuster/Claim Manager’s Name: Claim #: Phone:

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| --- | --- |
| **Primary Insurance** | **Subscriber name on card** |
| Insurance Name:  ID Number:  Group #: | Name of Subscriber:  Relationship to patient:  Date of Birth: |
| **Secondary insurance** | **Subscriber name on card** |
| Insurance Name:  ID Number:  Group #: | Name of Subscriber:  Relationship to patient:  Date of Birth: |

Referring Physician: Date Returning to Physician:

**Assignment of Benefits/authorization to release medical information/consent to treat**

I hereby assign all medical benefits to which I am entitled to Summit Health Physical Therapy in the event they file insurance on my behalf. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Summit Health Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature (over 18 years old) Date