BODY IN BALANCE

PHYSICAL THERAPY

Patient Demographic Form

Name:____ D.O.B.______________________

Address:____

City:_________________________________ ZIP:_____________ CELL#: _______________________

Home#:______________________________ Email: ____

Referring MD:______________________________ Primary MD:____________________________

Who can we thank for referring you? (circle one): Physician Friend/family Web Other:___________

If friend/family, name: ____

Name of insured:____ Insured DOB:_______________

Pt. relationship to insured:____

____

Is this related to an accident? YES NO If yes, what type? AUTO WORK OTHER

Name of attorney:_______________________________________ Phone: ______________________

Is this work-related? YES NO If Yes, please complete the following:

Date of Injury:______________________ Have you filed for worker's compensation? YES NO

Name of Employer:__________________________________ Phone:_________________________

Contact Person/Case Manager:______________________________ Phone:__________________

For office use only

Diagnosis:____

Start of care: _____/______/______ Insurance:_________________________________