Susan Underwood Physical Therapy
Patient Information

Last Name: ______________________ First Name: ______________________ MI: ________

Date of birth: ______________________ Social Security #: ______________________

Street Address: ______________________ City: ______________________ State: ________

Zip: ____________ Email Address: ______________________________________

Please indicate the preferred contact number by circling.

Home #: ______________________ Work #: ______________________

Cell #: ______________________ Fax #: ______________________

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Emergency Contact Information

Name: ______________________ Relationship to Patient: ______________________

Home #: ______________________ Cell #: ______________________

Patient Employment Information: ☐ Full time ☐ Part Time ☐ Retired ☐Student

Employer Name: ______________________________________

Street Address: ______________________ City: ____________ State: ______ Zip: ________

Phone #: ______________________ Fax #: ______________________

Insurance Policyholder and/or Responsible Party Information

Primary Insurance: ______________ Policy Holder: ______________ DOB: __________

Secondary Insurance: ______________ Policy Holder: ______________ DOB: __________

Tertiary Insurance: ______________ Policy Holder: ______________ DOB: __________

Billing Information: ☐ Same as Patient ☐ If different please fill out the following information:

Last Name: ______________________ First Name: ______________________ MI: ______

Street Address: ______________________ City: ______________ State: _____ Zip: ________

Home #: ______________________ Work #: ______________________

Date of Birth: ______________ Sex: ☐ Male ☐ Female Social Security #: ______________

Relationship to Patient: ______________________________________

Employer Name: ______________________________________

City: ______________________ State: ____________ Zip: ____________

Phone #: ______________________ Fax #: ______________________

Patient Medical Information

Physician Referral: ______________________ Phone#: ____________ Fax#: ____________

Location: ______________________________________

You are being treated for: Work Injury / Auto Accident / Other ______________________

I consent to treatment necessary for the care of the above named patient.

I authorize the release of any medical or other information necessary to process this claim if applicable.
I also request that government benefits or other medical benefits be assigned to Susan Underwood Physical Therapy Clinic for procedures and/or services rendered.

______________________________________ ______________________

Patient Signature **Date**

______________________________________ ______________________

Patient Representative/Guardian Signature **Date**