Atlas Physical Therapy and Industrial Rehabilitation

Patient Information

First Name: _____ **Last Name:**_____

Date of Birth: ____/____/____ **Sex: Male/Female** **SS#:**_____-_____-_____

Email: _____

Address: _____**City:** _____**State:** _____ **Zip:**_____

Home Phone: (____) _____ -_____ **Cell Phone:** (____) _____ -_____ **Work Phone:** (____) _____ -_____

***We will leave pertinent information on your voicemail unless otherwise requested**

Spouse/Domestic Partner: _____

Parent/Guardian (if applicable):_____

Employer: _____ **Occupation:** _____

Employment Status: **Full Time** **Part time** **Retired** **Unemployed**

Are you currently off work because of this problem? Yes No Light duty

Referring Practitioner: _____ **Phone:** (___) _____ -_____

INSURANCE INFO:

PRIMARY INS: _____**Subscriber:** _____ **Date of Birth:** ____/____/____

ID#_____ Group#_____

Secondary Insurance: _____Subscriber: _____ Date of Birth: ____/____/____

ID#_____Group#_____

Work Injury Auto Claim Claim#: _____ Date of Injury: ____/____/_____

Claim Manager/Adjuster: _____Phone: (____) _____ -_____ Ext: _____

Address: _____ City: _____ State: _____ Zip: _____

Attorney Name: _____ Law Firm: _____Phone: (____) _____ -_____

Address: _____ City: _____ State: _____ Zip: _____

****IN CASE OF EMERGENCY PHONE:** (____) _____- _____ **Name & Relationship to Patient:** _____

Do you give permission to discuss your medical info with the above listed emergency contact? Yes No

Patient or Guardian Signature: _____ **Date:** ____/____/_____