

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_