GENERATIONS R.C., INC. Generations Physical Therapy 304.760.5660

Date: _____ Patient Number: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Street Address (or PO Box): _____ City: _____ State: _____ Zip: _____

Home &/or Cell Phone: _____ Work Phone: _____ Ext.:_____

Employer Name & Address: _____

Social Security Number: _____ Marital Status: (M) (S) (D) (W) Student Status: (P) (F) Sex: (M) or (F)

Primary Care Physician: _____ Location: _____ Phone: _____

How did you hear about our facility: _____ Email Address: _____ (For Exercise Correspondence)

Medical Information

Return to referring doctor date: _____ Nature of injury/accident: _____

Attorney Name: _____ Phone: _____

Accident Date: _____ Do you have a Letter of Protection? Y or N

Diagnosis/Symptoms: _____ Precautions: _____

Have you had any physical, speech, occupational, chiropractic treatments this year? Yes or No

Insurance Information

Primary Insurance: _____ Address: _____

Policy Number: _____ Group Number: _____

Name of Card Holder: _____ SSN: _____ Date of Birth: _____

Card Holder Employer, Address, and Phone: _____

Secondary Policy: _____ Address: _____

Policy Number: _____ Group Number: _____

Name of Card Holder: _____ SSN: _____ Date of Birth: _____

Employer, Address, and Phone: _____

Emergency Information: In case of emergency notify the following people

1. _____ Relationship: _____ Phone: _____

I hereby consent to treatment by Generations Physical Therapy and authorize the release of any and all information acquired in the course of my treatment or dealing in any manner with my treatment, including, but not limited to medical records, electronic media, oral communications or other information of any type to mu insurance company, employer or other third party payor. I agree to hold Generations Physical Therapy harmless from the release of any of the above information. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize payment to be made directly to Generations Physical Therapy got all services rendered.

Patient/or Authorized Representative: _____ Date: _____