

THE DESERT INSTITUTE OF PHYSICAL THERAPY

PATIENT NAME:		SEX: MALE _____ FEMALE _____	AGE:	BIRTH DATE:
RESPONSIBLE PARTY:			RELATIONSHIP:	
ADDRESS:		CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	CELL PHONE:	EMAIL:	MAY WE EMAIL YOU WITH CLINIC INFO? YES _____ NO _____
EMPLOYER:			EMPLOYER PHONE:	
REFERRED BY:		MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ SEPARATED _____		
ANY MEDICAL ALLERGIES? YES _____ NO _____ IF YES, PLEASE LIST				
EMERGENCY CONTACT:		PHONE:		
CASH _____ PRIVATE INSURANCE _____ WORK COMP _____ THIRD PARTY RESPONSIBLE? YES _____ NO _____ MOTOR VECHICLE _____ PERSONAL INJURY _____				
RESPONSIBLE INSURANCE COMPANY NAME:				
RESPONSIBLE INSURANCE COMPANY ADDRESS:		PHONE:		
INSURED'S NAME:		ID #:	GROUP #:	
IS INJURY ACCIDENT RELATED? YES _____ NO _____	DATE OF INJURY:	CLAIM #:	ADJUSTER:	PHONE:

I HERBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PARTY OR GROUP INDICATED ON THE CLAIM. I UNDERSTAND I AM ULTIMATELY FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

DATE _____ SIGNATURE – PATIENT OR GUARDIAN _____