ADVANCED PHYSICAL THERAPY, LLC
4000 OLD COURT RD #100
PIKESVILLE, MD 21208
PHONE: 410-415-0005
FAX: 410-415-0006

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE #: _____ WORK#: _____ CELL#: _____

D.O.B:_____ MALE / FEMALE

EMAIL: _____

EMPLOYER NAME: _____ OCCUPATION_____

PRIMARY CARE PHYSICIAN: _____

INJURY RELATED TO: WORK_____ AUTO: _____ OTHER: _____

ALLERGIES OR MEDICAL PRECAUTIONS: _____

EMERGENCY CONTACT: _____ PHONE#_____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

HEALTH INSURANCE INFORMATION

INSURANCE CARRIER: _____ PHONE#:_____

I.D #:_____ GROUP#:_____

POLICY HOLDER NAME: _____ D.O.B_____

AUTO INSURANCE INFORMATION

INSURANCE CARRIER: _____

PHONE #: _____

ATTORNEY NAME/NUMBER: _____

I HEREBY ACCEPT RESPONSIBILITY FOR THE COST OF EXAMINATION OR TREATMENT IN THE EVENT THAT THE INSURANCE COMPANY DENIES MY CLAIMS.

I UNDERSTAND AND AGREE THAT IT IS MY RESPONSIBILTY TO NOTIFY ADVANCED PHYSICAL THERAPY, LLC 24 HOURS IN ADVANCE IF I AM UNABLE TO KEEP MY SCHEDULED APPOINTMENT. OTHERWISE, THERE WILL BE A $25 CHARGE ASSESSED TO MY ACCOUNT (NOT COVERED BY INSURANCE).

PATIENT'S SIGNATURE: _______DATE:_____