PATIENT INFORMATION SHEET

WELCOME TO FAIRHOPE PHYSICAL THERAPY

Patient's Name:_____Date of birth:_____

Social Security Number:_____Age:_____Sex: M F

Address:_____

City:_____State:_____Zip code:_____

Home Phone Number: ( )_____ Work:( )_____Cell( )_____

Is it OK to contact you by our cell number: Yes No

Patient Employer:_____Student:_____

Occupation:_____

Marital Status: ◯Single ◯Married ◯Divorced ◯Widow

Spouse's Name:_____Parent's Name if minor:_____

Emergancy Contact:_____Relationship:_____Phone: ( )_____

Referring Physician:_____

Date of last visit with physicain:_____Next appt:_____

Type of injury: ◯ Workers Compensation ◯ Auto Injury ◯Other

*********COPY OF INSURANCE CARD AND DRIVERS LISCENSE IS REQUIRED**********

Primary Insurance:_____

Name of insured:_____

Relationship to patient:_____DOB (Insured):_____

Social Security Number:_____Policy Number:_____

Secondary Insurance(if any):_____

I hearby authorize Fairhope Physical Therapy Services Inc. to furnish insurance carriers information concerning my treatments. I authorize the release of medical records to these companies and to other physicians for the purpose of continuity of care.

Signature of responsible party:_____Date:_____