PRECISE PHYSICAL THERAPY

Patient Information – Minor Child

Last Name_____ First Name_____ MI_____ SEX_____
DOB_____/_____/_____ Age _____ SS# _____-_____-_____
Address _____
City_____ State_____ Zip_____
Home Phone _____ Cell Phone _____

MOTHER'S INFORMATION:
Last Name_____ First Name_____ MI_____ SEX_____
Marital Status (circle one) S M D W DOB_____/_____/_____ SS# _____-_____-_____
Address (if different than patient) _____
City_____ State_____ Zip_____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____ Work Phone ( ) _____
Employer Address _____ City/State/Zip _____

FATHER'S INFORMATION
Last Name_____ First Name_____ MI_____ SEX_____
Marital Status (circle one) S M D W DOB_____/_____/_____ SS# _____-_____-_____
Address (if different than patient) _____
City_____ State_____ Zip_____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____ Work Phone ( ) _____
Employer Address _____ City/State/Zip _____

EMERGENCY CONTACT INFORMATION
Last Name_____ First Name _____ Phone ( ) _____
Address (City/St/Zip) _____ Relationship_____

INSURANCE INFORMATION PLEASE PROVIDE COPY OF INSURANCE CARDS

Insurance Co. Name _____ Name of Insured _____
DOB _____/_____/_____ SS# _____-_____-_____ Relationship to Patient _____
Insured's Employer _____
POLICY # _____ GROUP # _____
Primary Care Physician Name _____ Phone Number _____

FOR RAPID PROCESSING OR YOUR CLAIMS PLEASE PROVIDE CURRENT INFORMATION. Please let us know of changes.

I do hereby authorize medical treatment/physical therapy for my minor child and the release of any medical or other information that may be necessary for either medical care/physical therapy or in processing applications for financial benefits. I also authorize direct payment of medical/physical therapy benefits to Precise Physical Therapy for services rendered. I understand that I am financially responsible for any balance covered by my insurance.

_____ _____
Patient Representative (Parent or guardian) Signature Date