

# ***Gillette Physical Therapy***

201 W Lakeway Suite 700 Gillette WY 82718 (307)682-4900

Thank you for selecting our team! We will strive to provide you with the best possible health care. To help us meet all your health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## **PATIENT INFORMATION:**

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse/Parent's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Any Health Problems We Should Know About? \_\_\_\_\_

## **EMERGENCY INFORMATION:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## **PRIVATE INSURANCE INFORMATION:**

Primary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**MEDICARE INFORMATION:**

Medicare #: \_\_\_\_\_

Supplemental Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDIC AID INFORMATION:**

Medicaid #: \_\_\_\_\_

**INDUSTRIAL INSURANCE INFORMATION (WORKERS COMP)**

Date of Injury: \_\_\_\_\_ Type of Injury: \_\_\_\_\_

Employer at Time of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services, I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorneys fees incurred in attempting to collect on this amount or any future outstanding account balances.

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Parent/Legal Guardian if Minor