KETHLEY
Physical Therapy

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PATIENT INFORMATION SHEET

(if you have any questions about completing this form, please ask for assistance)

Date: _____ Email: _____

Name: First: _____ Middle: _____Last:_____

What name do you prefer to be called by: _____ Sex: M / F

Address: _____Home Phone: (_____)_____

City/State/Zip: _____Work / Cell: (_____)_____

Date of Birth:_____ Social Security Number:_____ Marital Status:_____

POLICY HOLDER'S INSURANCE INFORMATION:

Insurance Company's Name: _____
Policy Holder's Name: First: _____ Middle: _____ Last: _____
Sex: M / F Date of Birth: _____ Social Security Number: _____
Relationship to Patient: _____
□ Full Time □ Part Time □ Unemployed □ Student □ Retired, How Long? _____

SECONDARY INSURANCE (if applicable):

Insurance Company's Name: _____
Policy Holder's Name: First: _____ Middle: _____ Last: _____
Sex: M / F Date of Birth: _____ Social Security Number: _____
Relationship to Patient: _____

REFERRING PHYSICIAN:

Name: _____ Specialty: _____ Last Visit: _____
Other Physician: _____ Specialty: _____ Last Visit: _____
Other Physician: _____ Specialty: _____ Last Visit: _____

ADDITIONAL INFORMATION:

1. Are your injuries a result of a motor vehicle accident? Yes No
If Yes, Do you have Personal Injury Protection Insurance? Yes No Company: _____
2. Is this case currently involved in litigation? Yes No
Attorney's Name: _____ Phone: (_____)_____ Fax: (_____)_____
3. Have you received physical therapy for <u>any</u> condition this year? Y / N If so, how many visits? _____
4. Are you now or have you been receiving Home Health Care? Y / N
If Yes, please provide company name and discharge date. _____
5. How did you hear about Kethley Physical Therapy?
Doctor Friend Mail Yellow Pages Other:_____

PLEASE TURN OVER & FILL OUT PAST MEDICAL HISTORY FORM