

WESTGATE ORTHOPAEDIC PHYSICAL THERAPY & EXERCISE, INC. P.S.
PATIENT INFORMATION SHEET

PATIENT INFORMATION					
Patient Name:	Last	First	M.I.	Phone#:	
Patient Address:	Street	City	State	Zip	
SSN:	Sex: M/F	DOB:	Age:		
Patients Employer:		Occupation:			
Employers Address:			Work Phone:		
Name of Spouse or Guardian if a Minor:			DOB:	SSN:	
Emergency Contact Name:		Relationship:	Phone#:		
Reason for Visit:					
Injured Body Part include Left or Right if appropriate:					
Activities presently unable to do:					
Describe your pain (sharp, dull, aching, burning,etc)					
Have you been treated at Westgate Physical Therapy? Therapist:			How did you hear about Westgate Physical Therapy?		
Have you ever had physical therapy for this injury? Y/N			Where:		
Work Related: Y/N	Motor Vehicle Accident: Y/N		Date/Time of Injury:	Surgery Y/N	Date
How did the injury happen:			Where did the injury happen:		
INSURANCE INFORMATION CO PAYMENTS ARE EXPECTED AT TIME OF SERVICE					
Primary Insurance Name:		ID#:		Group#:	
Subscriber Name:	DOB:	Relationship to the Patient:			
Secondary Insurance Name:		ID#:		Group#:	
Subscriber Name:	DOB:	Relationship to the Patient:			
Auto Insurance Name:			Claim#:		
Adjuster's Name:			Phone#:		
Attorney Name:			Phone#:		
Attorney Address:		STREET	CITY	ZIP	

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR INSURANCE CARD TO PHOTO COPY

