Patient Demographics: **Date:_____**

Patient Name: _____ **D.O.B**.____/_____/_____ **SS#**_____

□ **Male** □ **Female** □ **Minor** □ **Single** ■ **Married** ■ **Separated** ■ **Divorced** ■ **Widowed**

PATIENT'S HEIGHT:_____ WEIGHT: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: (_____)_____

EMAIL: _____ REFFERRED BY: _____

I AUTHORIZE MY PHYSICIAN'S OFFICE TO CONTACT ME USING ANY OF THE ABOVE CONTACT INFORMATION _____(please initial)

INSURANCE INFORMATION

PRIMARY INS: _____ POLICY #: _____

GROUP #:_____ SUBSCRIBER'S NAME: _____

D.O.B:_____ SS#:_____ RELATIONSHIP:_____

EMPLOYER'S ADDRESS: _____ PHONE# (_____)_____

SECONDARY INS: _____ POLICY #: _____

GROUP #:_____ SUBSCRIBER'S NAME: _____

D.O.B:_____ SS#:_____ RELATIONSHIP:_____

EMPLOYER'S ADDRESS: _____ PHONE# (_____)_____

EMERGENCY CONTACT

NAME: _____ PHONE #: _____

RELATIONSHIP:_____ HOME ADDRESS:_____

BY MY SIGNATURE BELOW I AFFIRM:

All of the information included on this form is correct and accurate. I will be responsible to inform this office of any changes in address, phone number, employment, and insurance information by requesting and completing a new information form. Any outstanding balance such as co-pay/co-ins, deductibles, denials due to changes in coverage or non participating plans is the patients responsibility. Outstanding patient responsibility older than 60 days after the date of service will be charged a late fee of 1.5% per month. I will also assume full responsibility for obtaining any necessary referrals. Co-pays, which are not paid at the time of service and require a patient billing statement, may be subject to an additional processing fee of $25.00.

Assignment: I hereby assign my insurance benefits to be paid directly to this practice. I understand I am financially responsible for all non covered services.

I acknowledge that I received All Star Physical Therapy PC's Notice of Privacy Practices

Patients Signature:_____ Date:_____