SOUND PHYSICAL THERAPY

PATIENT INTAKE REGISTRATION FORM

Phone (206) 301-0600
Fax (206) 301-0601

PATIENT INFORMATION

Patient Name: _____ Gender: M or F
LAST FIRST MI

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____

Address: _____APT# _____

City _____ State _____ Zip _____

Appt. Confirmation: Text: ○ OR Call: ○

Primary #: (_____) _____-_____ H ○ C ○ Secondary #: (_____) _____-_____ H ○ C ○

Work #: (_____) _____-_____ Email: _____

Alternate Contact (not living at the above address):

Name: _____ Phone# (_____) _____-_____ Relation: _____

INJURY INFORMATION

Referring Physician: _____

Diagnosis or chief complaint _____

Injury or Onset Date: _____ Date of surgery (if applicable) _____

INSURANCE INFORMATION

Insurance Name:_____

HEALTH INSURANCE Subscriber ID#_____Group#_____

Subscbr Name: _____ SubscbrEmployer: _____

Relationship: ○ self ○ spouse ○ dependent Subscriber's birthdate: _____/_____/_____

WORK INJURY: CLAIM# _____ Employer:_____

Claim Adjuster Name _____ Have you had previous PT for this injury? Y ○ N ○

AUTO ACCIDENT: PIP Claim# _____ What State occurred? _____

Adjuster Name: _____ Driver ○ or Passenger ○

****please note your personal PIP benefits will be billed for you, however we do not bill 3rd party or liability insurance****