



P R E M I E R
PHYSICAL THERAPY

Where it's all about you... all the time.

Premier Physical Therapy and Wellness, Inc.

Patient information

Patient's Name _____

LAST

FIRST

MI

DOB: _____ SS # _____

Address _____

City _____ State _____ Zip _____

Phone: Home # _____ Work # _____ Cell # _____

Email address: _____

Emergency Contact Information:

Name: _____ Relation: _____

Phone # _____

How did you hear about Premier?

INSURANCE INFORMATION

Primary Insurance _____

Insurance ID# _____ Group # _____

Secondary Insurance _____

Insurance ID# _____ Group# _____

DIAGNOSIS INFORMATION

Referring Doctor _____

Cause of Condition: Illness _____ Job Related _____ Auto Accident _____ Other _____

Date of Injury _____

Location of Injury/Condition (i.e. body part) _____

Briefly describe how the condition occurred: _____

EMPLOYMENT INFORMATION

Are you a student? Yes _____ No _____

Are you employed? Yes _____ No _____ If yes, full time? Yes _____ No _____

Employer _____ Occupation _____