

PATIENT INFORMATION FORM

Please Print

Date

Patient's Last Name:	First Name:	Middle Name:	
Street Address:	Apt.#	City:	State: Zip:
Mailing Address (if different than above):		E-mail Address:	
Home Phone:	Sex:	Marital Status:	Referred by:
Social Security No.:	Date of Birth:	Age:	
Employed by:	Occupation:	Business Phone:	
Employer's Address:			
Spouse's Name:		Business Phone:	
Employed by:	Employer's Address:		
Nearest Friend or Relative not residing with you:			
Relationship:		Telephone:	

MEDICAL INSURANCE INFORMATION

PRIMARY	SECONDARY
Insurance Company:	Insurance Company:
Policy No. Group No.	Policy No. Group No.

Is this a Work Comp claim: Yes or No Date of Injury Claim #

RESPONSIBLE PARTY INFORMATION

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF SOMEONE OTHER THAN THE PATIENT WILL BE RESPONSIBLE FOR THE BILL.

Name:	DOB:		
Address:	City:	State:	Zip:
Home Phone:	Relationship to Patient:	Social Security No.:	
Employer:	Employer's Address:	Business Phone:	

I hereby authorize **Lakeside Physical Therapy/Polson Physical Therapy** to furnish the insurance company or others not authorized by law with full information regarding treatment rendered, when so requested. I understand and agree that health and accident insurance policies are arranged between my insurance carrier and myself. I agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that it is my responsibility to know the provision of my insurance policy. Should my insurance company fail to pay my claim, I agree to pay in full.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I have been given a copy of this notice and have had a chance to ask questions about how my personal health information will be used. I know that I can contact the Privacy Official at **406-883-8101** if I have further concerns.

Signature _____

Date _____