PHYSICAL THERAPY
UNLIMITED, Inc.

PATIENT INFORMATION / DEMOGRAPHICS
PLEASE PRINT

PATIENT NAME_____

REFERRING PHYSICIAN:_____ FACILTIY SEEN:_____
NEXT APPOINTMENT WITH YOUR REFERRING MD: DATE_____ TIME:_____
PRIMARY CARE PHYSICIAN_____
HOME ADDRESS:_____ CITY:_____ ZIP:_____
MAILING ADRESS IF DIFFERENT THAN ABOVE:_____
HOME PHONE:_____CELL PHONE:_____
PRIMARY PHONE(circle one):HOME/CELL E-MAIL ADDRESS:_____
WOULD YOU LIKE APPOINTMENT REMINDERS E-MAILED TO YOU: YES/NO
DATE OF BIRTH:_____AGE:_____SOCIAL SECURITY NUMBER:_____
EMPLOYER;_____OCCUPATION:_____
WORK ADDRESS_____ WORK PHONE:_____
DATE OF RETIREMENT:_____

SPOUSE/PARENT:_____ DOB:_____SOCIAL SECURITY NUMBER:_____
EMPLOYER:_____
WORK ADDRESS:_____CITY:_____ZIP:_____
DATE OF RETIREMENT:_____

IS THIS A WORK RELATED INJURY?_____IF SO, DATE OF INJURY_____
IS THIS INJURY CAUSED BY AN AUTO ACCIDENT?_____ _IF SO, DATE OF ACCIDENT_____

NAME OF RELATIVE OR FRIEND TO CONTACT IN CASE OF EMERGENCY_____
PHONE NUMBER:_____CELL NUMBER:_____

INSURANCE INFORMATION:

- PRIMARY INSURANCE:_____
  ADDRESS:_____PHONE#_____
- SECONDARY INSURANCE:_____
  ADRESS:_____PHONE #:_____
- MEDICARE NUMBER_____DATE OF RETIREMENT:_____

WORKERS COMPENSATION INFORMATION:

EMPLOYER AT TIME OF INJURY:_____
NAME OF INSURANCE CARRIER:_____PHONE#:_____
ADDRESS:_____CITY:_____ STATE:_____ZIP: _____
CLAIM NUMBER:_____ADJUSTERS NAME:_____