PATIENT ADMISSION FORM

Account number: _____ Appointment Date: _____

Chart Number: _____ Physical Therapist: _____

Referring Physician: _____ Phone #: _____- _____-_____

Referring Physician NPI#: _____ Fax #: _____ - _____ - _____

For Office Use Only

DATE _____

HOME PHONE # _____ CELL PHONE # _____ OTHER PHONE # _____

NAME _____ SOCIAL SECURITY # _____

MAILING ADDRESS _____ CITY _____ STATE _____ZIP _____

BIRTH DATE _____ AGE _____ STATUS (circle one): S M W D SEX (circle one) M F

SPOUSE'S NAME _____ SPOUSE'S S.S.# _____ D.O.B._____

MAJOR COMPLAINT/DIAGNOSIS _____

DATE OF ACCIDENT/INJURY _____ TYPE (circle one): WORKER'S COMP AUTO OTHER

EMERGENCY CONTACT _____ PHONE # _____

EMPLOYER NAME_____

EMPLOYER ADDRESS _____

EMPLOYER PHONE _____

NEXT DOCTOR'S APPOINTMENT (date) _____

PRIMARY INSURANCE _____ POLICY ID # _____

POLICY HOLDER _____ POLICY HOLDER S.S.# _____

SECONDARY INSURANCE _____ POLICY ID # _____

POLICY HOLDER _____ POLICY HOLDER S.S.# _____

Have you received any physical therapy services this year? (circle one) Y N If yes, how many visits? _____
Who is responsible for this bill? _____
Will you be paying by (circle one) CASH CHECK CREDIT CARD

I acknowledge the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of treatment. I irrevocably assign all benefits to LSU-HSC Physical Therapy Clinic. I authorize release of medical records to my doctor and insurance company. If my reason for seeking treatment is the result of a work-related or personal injury claim, I also release information to my attorney, claims adjustor and my employer. I also authorize any physician or medical facility to release information relevant to LSU-HSC Physical Therapy Clinic. I understand and agree that (regarding my insurance status), I am ultimately responsible for the balance of my account for any professional services.

PATIENT'S SIGNATURE: _____ DATE _____