NEW RETURN PHONE-IN WALK-IN APPT DATE/TIME PT ICD10's_____

Patient Information

	Nickname	Birthdate	Social Security #	Home Phone
Address	Cell Phone	Marital Status S M D W Legally Sep	Gender	Drivers License #
	Referring Physician	Seeking therapy for	Date & Type of Surgery	
Occupation	Patient's Employer & Work Address			Employer's Phone
Primary Care Physician	Emergency Contact's Name		Contact's #	Relationship to Patient
EMAIL ADDRESS			WOULD YOU LIKE ADDED TO OUR E-MAIL LIST ?	
			YES _____	NO _____
Is your condition the result of an accident or injury? If so, provide how, where & in which state injury occurred.			**If injury is due to auto/other accident, please ask receptionist for a PI form**	
Date of Injury, if applicable	If a work-related injury, employer name at time of injury		Case Manager/Claims Adjustor Name & Phone	

Insurance Information

Primary Insurance Name	Policy #,WC or Auto Claim #	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known
Secondary Insurance Name	Policy Number	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known
Tertiary Insurance Name	Policy Number	Group Number	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address			Policyholder's Phone
PolicyHolder's Employer, work address and phone (if PH is other than patient)			Policyholder's SSN	Copay Amount, if known

Other Pertinent Information

Have you had any Physical or Speech Therapy this year? Yes No If so, how many visits of PT _____ & ST _____

Have you had any Occupational Therapy this year? Yes No If so, how many visits? _____

Are you receiving Home Health Services of any kind at this time? **Yes** No ***If yes, please inform receptionist at this time.***

Have you received any type of Home Health Services? Yes No If so when were you discharged (your final visit)? _____

Regarding Privacy: I have read a copy of STPT'S Privacy Policies (sign & date) _____

Please initial the following that are acceptable to you: STPT/VPS staff may leave messages with a person at my home _____ , and/or on my voicemail/answering machine at home _____ , work _____ or cell phone ____.

STPT/VPS can discuss my account or care with the following individual

I give my consent for treatment, authorize the release of necessary information to insurance carriers & appropriate personnel, & request that my insurance carriers pay STPT directly. If direct payment is not permitted, I request that payment be issued jointly to STPT & myself and mailed directly to STPT. I will endorse checks so STPT may cash & apply to my account accordingly. I understand I am financially responsible for any and all charges incurred. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.

Patient/Guardian Signature_____ Date _____