Gainesville Physical Therapy & Wellness
"Where People Matter and Results Count"

Patient Information Page 1 of 2

*We cannot process your insurance claim without the required fields filled out

Patient's name*: ____ Today's date: ______________
Street address*: ____ SSN*: ________________________
City and State*: ____ Male Female
Zip Code*: ____________________ Home phone: __________________ Date of Birth*: ___/___/___
Work phone: _________________________ Cell: ___________________ Age: _____
Email: ____
Family Physician:_______________________ Phone:_____________________
Person to contact in case of emergency: ____
Phone: (______) _______________________ Relationship: ____
Have you ever been seen in our office, as a patient before? Yes No If yes, date seen? _________________

PRIMARY INSURANCE COMPANY NAME: ____
Group number: _______________________ Policy number: ______________________________________
Insurance company billing address: ____
Policyholder's name*: ____________________________ Relationship to patient: ______________________
Policyholder's date of birth*: ___ / ___ / ___ Male Female Policyholder's SSN*: _________________
Place of employment: ____
Employer's street address: ____

SECONDARY INSURANCE COMPANY NAME: ____
Policy number: _______________________ Group number: ______________________________________
Insurance company billing address: ____
Policyholder's name*: ____________________________ Relationship to patient: ______________________
Policyholder's date of birth*: ___ / ___ / ___ Male Female Policyholder's SSN*: _________________
Place of employment: ____
Employer's street address: ____

IS THIS A WORKER'S COMPENSATION CLAIM? ☐Yes ☐No Date of Injury: _________________
Company: ___________________________ Address: ____
Phone Number: _____________ Claim #: ______________Contact Person: ___________________________

IS THIS AN ACCIDENT CASE? ☐Yes ☐No ☐Vehicle ☐Other_____________________________
Insurance Company to Bill: ___________________________Adjuster Name:_________________________
Address:____
Street City State Zip
Phone #: ___________________________Claim #:____

How did you obtain our name?

Friend Physician Yellow Pages Web site Other ____________________________

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Patient Information Page 2 of 2

Referring Doctor: ______________________ Phone: ________________ Last Appt. __________________
Is there pending litigation concerning your injury? ____
If yes, attorney name: ________________________ Phone: _______________________________________
Attorney address: ____

Date of Injury/onset of Symptoms: ___________________
Area(s) to be treated: ____
Surgeries and dates related to this injury: ____
Result of Auto Accident Yes No Date__________ Result of Work Injury Yes No Date__________
Place of employment at time of injury: _________________________________Phone: _________________
Current place of employment:________________________________Occupation:_______________________

I consent to Gainesville Physical Therapy & Wellness, LLC. for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Gainesville Physical Therapy & Wellness, LLC. to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:
Worker's Compensation Patient/Guardian Attorney Rehabilitation Intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to Gainesville Physical Therapy & Wellness, LLC. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Gainesville Physical Therapy & Wellness, LLC.
Print Name: ____
Client's Signature: _______________________________________ Date: __________________

I have read and understand Gainesville Physical Therapy & Wellness, LLC.'s privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

____
Client's Signature Date

I have read and understand Gainesville Physical Therapy & Wellness, LLC.'s billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

____
Client's Signature Date

____
Responsible Party's Signature (if patient is a minor) Date

____
Witness Print name Witness Signature Date

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