PALMER PHYSICAL THERAPY for WOMEN, INC
PATIENT INFORMATION SHEET
(Please print in black ink)

Name____ Date_____________________________

Address____ SS#______________________________

City_____________________ State______ Zip__________ Date of Birth______________ Age_______

Email Address______________________________________ Home Phone________________________

Referring Physician__________________________________ Work Phone________________________

Primary Care Physician ______________________________ Cell Phone _________________________

Work Status (circle one)

Full time /Part time / Retired / Disability/ Medical Leave / Other

Marital Status: (circle one)

Married Single Divorced Widowed Other

Date of Injury ____________________________________

Sex (circle one) Female Male

How did you find out about us? ☐ TV ☐ Radio ☐ Billboard ☐ Website ☐ Doctor ☐ Other ______________________

Emergency Contact__________________________________ Relationship_________________________

Home Phone____ Work Phone__________________________

Patient Current Employer______________________________ Phone_______________________________

Address_____________________City___________________ State_________ Zip___________

First Insurance_____________________________________ Phone#_____________________________

Plan Name/Type ____________________________________ Fax #______________________________

Address____ Subscriber ID #_______________________

City_____________________ State______ Zip__________ Group #____________________________

Insured's Name__________________________________ **Date of Birth** ________________________

Insured's Employer/Address____________________________ Relationship to Patient __________________

Second Insurance____________________________________ Phone#_____________________________

Address____ Policy#_____________________________

City_____________________ State______ Zip__________ Group #____________________________

OFFICE USE ONLY – Episode 1

Date of First Visit ___________________ Billing Therapist _______________ Referring Physician ___________________________

NPI Number ____________________________________ Specialty ____

Address _______________________________________ City ________________ State ___________ Zip Code ____________

DX __________________ DX __________________ DX __________________ DX __________________ DX __________________

Revised 5/6/14