NEW PATIENT DEMOGRAPHIC SHEET

LAST NAME: ________________________ FIRST NAME : ______________________________________ MI:__________

HOME ADDRESS: ____

CITY:_______________________________ STATE: ____________________ZIP: _____HOME PHONE : ________________

CELL PHONE : ______________________ WORK PHONE : _____________________DATE OF BIRTH: ______________

SEX : MALE FEMALE SOCIAL SECURITY#: ____________________E-MAIL ADDRESS: ______________________

EMERGENCY CONTACT: ____________________________RELATIONSHIP: ___________ PHONE: _________________

FAMILY PHYSICIAN : ________________ PHONE : ___________________________SPOUSE NAME _________________

HOW DID YOU HERE ABOUT EXCEL REHABILITATION & SPORTS THERAPY? ____________________________________

FINANCIAL INFORMATION: (If the patient is a minor, parent to complete this information)

NAME OF RESPONSIBLE PARTY : __________________________________RELATIONSHIP : ____________________

ADDRESS : ____CITY: _______________ STATE: ________ZIP : __________

PHONE: ____

PRIMARY INSURANCE INFORMATION: Member ID# ____________________________

POLICY HOLDER NAME: _____________________________RELATIONSHIP : __________ DOB: ___________________

SECONDARY INSURANCE: Member ID# ____________________________

POLICY HOLDER NAME: _____________________________RELATIONSHIP : __________ DOB: ___________________

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify EXCEL REHAB/LIT/ ON & SPORTS THERAPY of any changes in my status or the above information. I hereby authorize any treatment(s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I also authorize EXCEL REHABILITATION & SPORTS THERAPY and its staff to call my home and leave messages regarding appointment with my spouse and/or answering machine. Furthermore, I authorize the use of facsimile transmission, e-mail transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment and healthcare operations.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: ____________________________________ DATE: ___________________