Appt Date:
Time:
PPW:
Location:

PATIENT INFORMATION

LAST NAME:		FIRST NAME:		MI	HOME PHONE / CELL PHONE:
DATE OF BIRTH:	AGE:	SEX: ☐ MALE ☐ FEMALE	SOCIAL SECURITY #	EMAIL ADDRESS:	
MAILING ADDRESS:			CITY:	STATE:	ZIP:
PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE):			CITY:	STATE:	ZIP:
PATIENT'S EMPLOYER:			OCCUPATION:	WORK PHONE:	
EMPLOYER ADDRESS:			CITY:	STATE:	ZIP:
TYPE OF INJURY: ☐ WORK ☐ AUTO ☐ OTHER:				DATE OF INJURY:	
REASON FOR VISIT:	REFERRING PHYSICIAN:			DATE OF PRESCRIPTION:	
PRIMARY CARE PHYSICIAN:	HOW DID YOU HEAR ABOUT US?			DATE OF SURGERY (if applicable):	
EMERGENCY CONTACT:		RELATIONSHIP:		PHONE NUMBER:	

SPOUSE/PARENT/GUARANTOR INFORMATION

LAST NAME:		FIRST NAME:		MI:	HOME PHONE:
DATE OF BIRTH:	AGE:	SEX: ☐ MALE ☐ FEMALE	RELATIONSHIP:		
ADDRESS:			CITY:	STATE:	ZIP:
EMPLOYER:			OCCUPATION:		WORK PHONE:
EMPLOYER ADDRESS:			CITY:	STATE:	ZIP:

INSURANCE INFORMATION

1. PRIMARY INSURANCE:					PHONE NUMBER:
POLICY / CLAIM #:		GROUP #:			EFFECTIVE DATE:
DEDUCTIBLE:	PORTION MET:	OUT OF POCKET:	PORTION MET:	PATIENT RESPONSIBILITY:	
LIMITATIONS:				PRE AUTH REQ:	
2. SECONDARY INSURANCE:					PHONE NUMBER:
POLICY / CLAIM#:		GROUP #:			EFFECTIVE DATE:
DEDUCTIBLE:	PORTION MET:	OUT OF POCKET:	PORTION MET:	PATIENT RESPONSIBILTY:	
LIMITATIONS:				PRE AUTH REQ:	

I have read the above estimation of benefits from my insurance company and agree to verify this information by contacting my insurance company. I do not hold Peak Performance Physical Therapy & Sports Training responsible for any incorrect or omitted information or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and my insurance company.

SIGNATURE: ________________________________ DATE: ______________________