ALLAIN PHYSICAL THERAPY, LLC
PATIENT INFORMATION FORM

PATIENT:_____ Date of Birth:_____
Street Address:_____City_____ State/Zip:_____
Cell Phone #:_____ Home Phone #:_____
2ndary Contact # _____ Name _____

EMAIL /Confirmation of Appts: _____

How did you hear about Allain Physical Therapy?
___ Referral from Doctor ___ Dr _____
___Family/Friend - Name _____
___Website ____ Insurance Co ___ Advertisement ___ Other _____

INSURANCE: Please be sure you are familiar with your health plan's benefits for PT. (i.e. co-pay, deducible, number of visits allowed, authorization/referral requirements) You will be responsible for any balance due.

Primary Insurance _____ Member ID # _____
Subscriber Name _____Subscriber's Date of Birth: _____
Secondary Insurance: _____ Member ID # _____
Subscriber Name _____ Subscriber's Date of Birth _____
Referring Physician_____ Phone #:_____

INJURY/ WORKMANS COMP/ MVA: Date of Injury: _____
This problem is from: □ Sports □ Work □ Car Accident □ Other
Company: _____ Adjuster _____
Claim # _____ Tele_____ Fax: _____

MEDICAL : Please circle any of the following that applies:
__Asthma __Depression __Kidney disease __ Stomach ulcers __Blood clots __Diabetes __Multiple sclerosis __Stroke __Cancer __Heart problems __Osteoporosis __Thyroid problems __Chemical dependency __Hepatitis __Rheumatoid arthritis __Tuberculosis __Circulation problems ___High Blood pressure __ High Cholesterol __ OTHER :
_____

SURGERIES: _____

List any **Medications** you presently take :
_____
_____

Patient/Guardian Signature _____ Date _____