PATIENT INFORMATION FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	
ADDRESS			Garment Set(s) Required Upper Extremity ☐ LEFT ☐ RIGHT Lower Extremity ☐ LEFT ☐ RIGHT Head and Neck ☐
CITY	STATE	ZIP	
HOME PHONE	MOBILE PHONE	WORK PHONE	
EMAIL	DATE OF BIRTH	GENDER ☐ Female ☐ Male	
EMPLOYER	EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	

HOW DID YOU HEAR ABOUT US?
☐ Physician ☐ Therapist ☐ Internet ☐ Friend ☐ Advertisement ☐ Other:

INSURANCE INFORMATION

TYPE OF INSURANCE PLEASE CHECK ☐ **Private Health Insurance** ☐ **Workers' Comp** ☐ **Medicare** ☐ **Medicaid** ☐ **Self-Pay**

DATE OF INJURY IF WORKERS' COMP	WORKERS' COMP CLAIM NUMBER
PRIMARY INSURANCE COMPANY	PHONE NUMBER
NAME OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other
DATE OF BIRTH OF POLICY HOLDER	EMPLOYER
IDENTIFICATION NUMBER	GROUP NUMBER

SECONDARY INSURANCE COMPANY		PHONE NUMBER
NAME OF POLICY HOLDER	DATE OF BIRTH OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other
IDENTIFICATION NUMBER		GROUP NUMBER

PHYSICIAN INFORMATION

PRESCRIBING PHYSICIAN'S NAME		NPI (NATIONAL PROVIDER NUMBER)	
CLINIC NAME		PHONE	FAX
ADDRESS	CITY	STATE	ZIP

THERAPIST INFORMATION

THERAPIST'S NAME	
WORK EMAIL APPROVED TO EMAIL DOCUMENTS ☐ Yes ☐ No	
PHONE	FAX

FACILITY/CLINIC INFORMATION

FACILITY/CLINIC NAME		
ADDRESS		
CITY	STATE	ZIP

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