Patient Demographics

Name: _____ _____
First Middle Initial Last Nickname

SSN: _____ **Gender:** M / F **Marital Status:** Single Married Other Widowed Divorced

DOB: _____ **Patient Status:** Employed Full-Time Student Part-Time Student N/A

Address: _____ _____ _____ _____
Street City State Zip code

Email: _____

Phone: Home: _____ → Can we leave you a message? ___ Yes ___ No

Cell: _____ → Can we leave you a message? ___ Yes ___ No

Work: _____ → Can we leave you a message? ___ Yes ___ No

Can we discuss your medical condition with another person? If yes, who?: _____

- Please send me appointment reminders by _____ **text message** and/or _____ **E-Mail messages**

PCP Physician: _____ Referring Physician: _____

Primary Insurance: _____

Policy Holder: _____ Relationship to you: _____

Policy Holder Date of Birth: _____ Policy Holder Gender: M / F

Secondary Insurance: _____

Policy Holder: _____ Relationship to you: _____

Policy Holder Date of Birth: _____ Policy Holder Gender: M / F

I consent to rehabilitation and related services at Grant Spangle Physical Therapy. In so doing, I understand that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
I authorize payment of medical benefits to the undersigned supplier of services. I authorize the release of any medical or other information necessary to guarantee payment. I understand fully that in the event my insurance company does not pay for the service I receive, **I will be financially responsible for payment**. Accounts pas due are subject to an interest fee of 2% monthly on the unpaid balance. **All co-payments are due at time of service.**

I have read the above, agree to the terms and consent to treatment.

_____ _____
Patient Signature Date