oPTimum
Physical Therapy

Patient Name: _____ Male_____ Female_____
First Last Middle Initial (check one)

Home Address: _____ Home Phone: ( ) _____

City: _____ State: _____ Zip: _____ Cell Phone: ( ) _____

Email address: _____

Date Of Birth: _____ Age: _____ Social Security #: _____

Marital Status: M_____ S_____ D_____ W_____ Spouse's Name: _____
(If married please provide)

Employed By: _____ Work Phone: ( ) _____

In case of emergency we may call? _____ Phone#: _____

Name of Referring physician: _____ Last visit date: _____

Name of Primary Care Doctor: _____ Phone#: _____

Who referred you? Phone Book Doctor(if so, what date?:_____) Friend/Relative Other: _____

Did you have an accident?: Yes / No If yes: Work Auto Date of Injury: _____

Are you currently getting Home Health Care Services? _____ YES _____ NO

Do you currently have a visiting nurse come into your home? _____ Yes _____ NO

Primary Insurance	Phone
Address	Policy #
City/State/Zip	Group #
Insured's Name	Date Of Birth _____/_____/_____
Relationship to Patient	

Assignment of Benefits/Release Of Information:

I hereby authorize Optimum Physical Therapy to perform all treatments and procedures that they consider necessary for my benefit, upon consultation with my representative or myself. I understand that I am financially responsible for any balances not covered by my insurance. **I understand that there may be a $40 no show/cancellation charge if I fail to show up or call 24 hours in advance.**

Medicare Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made on my behalf to Optimum Physical Therapy.

Insurance Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me I applying for payment under the provisions of my medical insurance is correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Optimum Physical Therapy.

_____ _____
PATIENT SIGNATURE or AUTHORIZED REPRESENTATIVE DATE