Please bring this completed form, your insurance information and/or cards to your initial visit. It is the patient's responsibility to notify our office of any changes to the information provided on this form.
Thank you

PATIENT DATA SHEET

South Lane Physical Therapy LLC

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( )_____ WORK ( ) _____ CELL ( ) _____

EMAIL: _____ PREFERRED WAY TO CONTACT YOU: HOME WORK CELL SEX: MALE FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
MARRIED SINGLE WIDOWED SEPARATED OTHER

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMPLOYER NAME/ADDRESS: _____
STREET CITY, STATE ZIP

EMERGENCY CONTACT: _____ PHONE: _____
NAME/RELATION

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY.

IF THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION. IF THE PATIENT IS NOT A MINOR, THEN SKIP THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT MOTHER FATHER OTHER

NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME ( )_____ WORK ( ) _____ CELL ( ) _____

EMPLOYER: _____ SOCIAL SECURITY NUMBER: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? YES NO

PRIMARY INSURANCE NAME: _____ INSURED NAME: _____

PRIMARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

SECONDARY INSURANCE NAME: _____ INSURED NAME: _____

SECONDARY INSURANCE ADDRESS: _____ PHONE: _____

POLICY ID# _____ POLICY GROUP # _____ SEE COPY OF CARD

ACCIDENT INFORMATION: Was this injury the result of an accident? NO YES DATE OF ACCIDENT/INJURY: _____
MOTOR VEHICLE ACCIDENT WORK RELATED OTHER

HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from South Lane Physical Therapy, LLC and understand it completely.

CONSENT: By signing this form, I agree and give my consent for South Lane Physical Therapy Services, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ _____
Signature Date