S.T.A.R. Physical Therapy Patient Information Sheet

Please print all information clearly. Thank you!

First Name: _____MI: ____Last Name: _____Nick Name: _____

SS#:_____D.O.B.:_____/_____/_____ Age:_____ Gender: M F Marital Status: S M W D SEP

Home Phone. :_____ Cell:_____ Referring Physician:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

Mailing Address(if different from above):_____City:_____State:_____Zip Code:_____

E-mail Address: _____How Did you Hear about STAR:_____

Occupation:_____Employer:_____Work Ph:_____ Student: Y N

Spouse Information (Parent /Custodian if under 18) Name:_____ DOB:_____/_____/_____ Phone:_____

Emergency Contact (not living in household):_____Phone:_____

Who can we thank for recommending you to us other than your physician? _____ ☐ No one

If no one recommended you to us how did you hear about us?_____

Has anyone in your family been treated by one of our therapists?(If yes, Name/Relation)_____

Is condition accident related?(circle) : Y N If yes, type of accident(circle) : Auto Work Other
Date of Injury:_____/_____/_____

Payment Information (please circle who you would like your bills sent to) : Health Insurance Auto Insurance Worker's Comp Attorney

I hereby authorize STAR Physical Therapy to release any information (including medical or other) to any person or corporation which may include a family member or employer of the patient including, but not limited to, insurance companies, hospital or medical companies, workers compensation carriers, welfare funds, or the patient's employer. I fully understand that I am responsible for all amounts, including equipment and supplies, not covered by my insurance or attorney. I also understand that in the event my insurance carrier does not cover all charges, I am responsible for payment in full. If additional payer source becomes involved, above agreement is void and patient becomes responsible for payment in full. If necessary, S.T.A.R. Physical Therapy will be happy to set up a payment plan with the patient. I hereby authorize S.T.A.R. Physical Therapy to release any information (medical or other) to S.T.A.R. Fitness Center for the purposes of education and promotion regarding available wellness programs and benefits for up to one year following discharge from physical therapy. If you would like to waive your authorization to receive wellness program information please complete an authorization retraction form at the front desk.

_____ Date_____/_____/_____
Patient's Signature (Parent/Custodian's Signature if patient is under 18)