IMPACT PHYSICAL THERAPY

Date: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Sex: M F Marital Status: Married Single Divorced

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Would you like to receive appointment reminders? Text E-mail None

Employer: _____ Occupation: _____

E-mail address: _____

Would you like to receive e-mail updates from Impact? Yes, please No, thank you

Referring Physician: _____ Dx/Reason for Visit: _____

How were you referred to Impact? _____

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name: _____Relationship to patient: _____

Subscriber Date of Birth: _____ Group# _____ Policy /ID #_____

Ins Phone: _____

Name of Secondary Insurance: _____

Policy Holder Name: _____Relationship to patient: _____

Subscriber Date of Birth: _____ Group# _____ Policy /ID #_____

Ins Phone: _____

Worker's Comp

Employer: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Job Title: _____ Date of Injury: _____

Insurance Company: _____Phone: _____

Case Manager: _____Phone: _____