7932 W. Sand Lake Rd.
Suite 203
Orlando, FL 32819
(P) 407.355.9820
(F) 407.363.4571

Patient Information:

First Name: ______________________________ MI: _____ Last Name: ______________________________________
Address: ____
Apt. ____________ City: __________________________________ State: __________ Zip Code: _____________
Home Phone: ____________________ Work Phone: _____________________ Cell Phone: ____________________
Sex: M / F Marital Status: ____Married ____ Single ____Widowed ____Divorced
Date of Birth: _________________________ Age: __________ SS#: ________________________________
Employer: ______________________________________ Occupation: _______________________________
E-Mail: ____
Emergency Contact # __________________________ Name/Relationship _________________________________
Have you had physical therapy in the past? ____Yes ____No If yes, please answer the following:
When did you receive treatment?____
What diagnosis did you receive treatment for? ____

Doctor Information:

Referring Doctor (who wrote the Rx to come to therapy):____
Referring Doctor Address: ____
Referring Doctor Phone#: ___________________________________ Fax #: _____________________________
Date of initial Rx: ____
Primary Doctor:____ Phone #:_________________________________

Insurance Information:

Primary Insurance

Insurance Co: ____ **Ins ID #**_________________________________
Is this the Patient's insurance: ___Yes ___No If no, the name of the insured __________________________
Insured D.O.B: _______________________________ Relationship to the patient: ___spouse ___child ___other

Secondary Insurance

Do you have secondary insurance? Y / N
Insurance Co: ____ **Ins ID #** _________________________________
Is this the Patient's insurance: ___Yes ___No If no, the name of the insured __________________________
Insured D.O.B: _______________________________ Relationship to the patient: ___spouse ___child ___other

Patient Signature: ______________________________________ **Date:** _____________________________