Bigfork Physical Therapy
Patient Information Form

OFFICE USE: EVAL DATE _____
THERAPIST _____
ACCOUNT# _____

PATIENT INFORMATION
Have you been a Bigfork Physical Therapy patient before? _____Y _____N

First Name _____ Last Name _____
MI _____

Mailing Address
_____

City _____ State _____ Zip Code _____

* Please check which phone numbers we can leave message on

( ) Home Phone (_____) _____-_____

( ) Cell Phone (_____) _____-_____

( ) Work Phone (_____) _____-_____

E-Mail _____

Date of Birth ____/____/____ Social Security # _____-_____-_____

Marital Status: ( ) Married ( ) Single ( ) Other

Sex: ( ) Male ( ) Female

Referring Physician _____

Area of Injury _____

Emergency Contact _____

Emergency Contact Phone (_____) _____-_____

RESPONSIBLE PARTY INFORMATION

Who is responsible for payment? ( ) Self ( ) Other
Relationship if other: _____

IF OTHER THAN SELF:

Last Name _____ First Name _____
MI _____

Street Address
_____

City _____ State _____ Zip Code _____

Home Phone (_____) _____- _____

Work Phone (_____) _____-_____

WORKERS COMPENSATION OR AUTO ACCIDENT INFORMATION
MY INJURY WAS: ( ) Work Related ( ) Auto Related
Have you notified your insurance company yet? _____

Insurance Company
_____

If work accident: Name of workplace
_____

If auto accident: Name of insured person
_____

Policy/Claim # _____

Date of Injury or accident _____

In what state did injury occur _____

Case Manager/Claims Adjuster _____

Insurance Billing Address _____

City _____ State _____ Zip Code _____

Phone: (_____) _____-_____

Fax: (_____) _____-_____

PRIMARY HEALTH INSURANCE INFORMATION
(REQUESTED EVEN IF INJURY IS WORK OR AUTO ACCIDENT RELATED)
Bigfork Physical Therapy & Sports Rehabilitation, Inc. requires a copy of your insurance card be on file. Please give your card to the receptionist or therapist to photocopy. Thank you.

Talk to us about financial options if you are concerned about your insurance coverage! And please do so at the time of your first visit if possible.

Insurance Company
_____

Relationship to Subscriber ( ) Self ( ) Spouse ( ) Child ( ) Other

Subscriber Name _____

Subscriber Date of Birth _____

Policy _____
Group # _____

Insurance Billing Address
_____

City _____ State _____ Zip Code _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

SECONDARY HEALTH INSURANCE INFORMATION
As a courtesy, we are happy to bill your secondary insurance one time.
If you have questions, please contact our Billing Office.

Insurance Company
_____

Relationship to Subscriber ( ) Self ( ) Spouse ( ) Child ( ) Other

Subscriber Name _____ Subscriber Date of Birth _____

Policy _____
Group # _____

Insurance Billing Address
_____

City _____ State _____ Zip Code _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

ACKNOWLEDGMENT
I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to Bigfork Physical Therapy & Sports Rehabilitation, Inc.. I also acknowledge by signing below I accept the terms and agreements made by the attached Patient Financial Responsibility Form, Patient Registration and Consent for Medical Treatment Form.

_____ _____
Patient/Responsible Party Signature Relationship
Today's Date

I authorize that payment of any insurance benefits for health care services or goods may be made directly to