PATIENT INFORMATION

Name: Last First Middle

Sex: M / F Pronouns: She/Her He/Him They/Them

Social Security #: Date of Birth: Age:

Marital Status *(circle one)*: Single Married

Street Address:

City: State: Zip Code:

Cell: Alt. Phone:

Email Address:

RESPONSIBLE PARTY

Name: Last First Middle
(if different than patient)

Sex: M / F Pronouns: She/Her He/Him They/Them

Social Security #: Date of Birth: Age:

Marital Status *(circle one)*: Single Married

Street Address *(if different than patient)*:

City: State: Zip Code:

Cell: Alt. Phone:

Email Address:

Emergency Contact Name: Cell: Relation:

MINOR GUARDIAN INFORMATION

Custody *(circle one)*: Joint Single

Name Date of Birth:

Address *(if different than patient)*:

Cell: Alt. Phone:

Name: Date of Birth:

Address *(if different than patient)*:

Cell: Alt. Phone:

WHY DID YOU CHOOSE UTAH PHYSICAL THERAPY INC.?

Physician Referral	Self/Returning Patient	Facebook	Google Maps
Family/Friend	Attorney	Instagram	Drove By
Coach	Insurance/Case Manager	Internet Search	Other: _____

PRIMARY INSURANCE

Insurance Company:

Policy Holder: Date of Birth:

I have provided a copy of my card. Yes / No

SECONDARY INSURANCE

Insurance Company:

Policy Holder: Date of Birth:

I have provided a copy of my card. Yes / No

Third additional insurance check this box ☐ and write insurance information on reverse.

REFERRAL AND OTHER IMPORTANT INFORMATION

Name of Referring Physician *(if applicable)*: Office Phone:

Primary Care Physician *(if different than above)*: Office Phone:
Required for Medicare/Medicaid

Medical Reason for Physical Therapy:

Date of Injury / Accident / First Symptoms *(MM/DD/YY)*:

If Accident, where did it occur? Work - Home - Auto - Other

If Employment related, adjuster name: Phone:

If Auto accident, auto adjuster name: Phone:

Have you received surgery in relation to this injury? Yes / No
If yes, surgery date *(MM/DD/YY)*: Surgeon:

Have you received Physical Therapy, Chiropractic, Speech or Occupational Therapy within the last 12 months? Yes / No
If yes, what type and from where:

Have you received Home Health Care of any kind within the last 60 days? Yes / No
If yes, Home Health Company: Phone:

I do attest that the above information is accurate and correct to the best of my knowledge.

Signature: _____ **Date:** _____

Relationship to Patient : _____