

Welcome to Our Office

(Please print all information)

Date

Patient's Name			Date of Birth	Age
Street Address			SS#	
City	State	Zipcode	Home Phone #	
Guarantor: (Write self if self)		Relationship to patient (circle 1) Parent Spouse Other		
Guarantor's Employer		Occupation	How long employed?	
Employer's Address		Work Phone #	years	
Emergency Contact: Name		Relationship to patient (circle 1) Parent Spouse Other		Phone #
Address (if different than patient)				

Please present all insurance cards to receptionist

1st Insurance		2nd Insurance	
ID#	Group #	ID #	Group #
Name of Policyholder		Name of Policyholder	
Policyholder's Date of Birth		Policyholder's Date of Birth	
Policyholder's SS#		Policyholder's SS#	

Family Physician
Referred by:

Accident Information

Were you injured on the job?	No	Yes	Date of Injury
Was an automobile involved?	No	Yes	Date of Accident
Were x-rays taken of this injury or problem?	No	Yes	Where were they taken? (Name of hospital, etc)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I assign directly to Conforti Physical Therapy all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Conforti Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

For Office Use Only	Copayment: _____	# Visits Authorized: _____
Diagnosis code(s) _____		