Boca Raton Physical Therapy Center
"Lasting Results. Fewer Visits."
Formerly Center for Orthopedic & Spine Rehabilitation

PATIENT INFORMATION SHEET

NAME_____AGE_____

ADDRESS_____
Street

_____
city state zip
HOME PHONE(____)_____WORK PHONE(____)_____

CELL PHONE(____)_____EMAIL_____

DATE OF BIRTH_____SSN_____GENDER M/F_____

OCCUPATION_____MARITAL STATUS_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____

MEDICARE PATIENTS ONLY: ARE YOU CURRENTLY HAVING HOME HEALTH CARE? YES/NO
HAVE YOU HAD OUTPATIENT PHYSICAL THERAPY THIS YEAR? YES/NO

REFERRING DOCTOR_____LAST VISIT_____NEXT VISIT_____
FAMILY DOCTOR_____PHONE_____
SURGERY DATE_____ACCIDENT DATE_____
ATTORNEY/CASE MANAGER(if applicable)_____PHONE_____
IN CASE OF EMERGENCY, NOTIFY_____PHONE_____

HOW DID YOU HEAR ABOUT US?
DOCTOR_____**FRIEND**_____**OUR WEBSITE**_____
INSURANCE_____**MCKENZIE**_____**YELLOW PAGES**_____
SELF_____**OTHER**_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment if Ins. Co. does not cover them. I do/do not authorize (circle one) **Boca Raton Physical Therapy Center** to release identifiable personal information except when such release is required by law. I hereby authorize my Ins. Co. to **Boca Raton Physical Therapy Center** for claims filed assigned.

_____ _____
Patient signature or guardian (if minor) Date