

Myofascial Physical Therapy

New Patient Information

LAST NAME	FIRST NAME	DATE OF BIRTH	AGE
STREET ADDRESS		SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP	HOME PHONE
WORK PHONE	CELL PHONE/PAGER		FAX
EMAIL ADDRESS (we send occasional information about classes and events, we will not share your address with others)			
EMPLOYER NAME		OCCUPATION	

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE
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INSURANCE INFORMATION PLEASE PRESENT INSURANCE CARDS FOR COPYING

INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP AND D.O.B.		
CLAIM ADDRESS	CITY	STATE	ZIP	PHONE NUMBER ()
SUBSCRIBER SOCIAL SECURITY NUMBER		GROUP NUMBER		

HISTORY OF PROBLEM

PART OF BODY	SIDE R L	DATE OF INJURY/ONSET OF SYMPTOMS
WERE YOU INJURED ON THE JOB? *IF YES, PLEASE FILL OUT NEXT SECTION		WERE YOU INJURED DUE TO AN AUTO ACCIDENT?

WORK RELATED INJURIES

NAME OF CARRIER	CLAIM ADJUSTER	PHONE NUMBER ()
CLAIM ADDRESS		CLAIM NUMBER
EMPLOYER (AT TIME OF INJURY)	DO YOU HAVE AN ATTORNEY? (IF YES PLEASE LIST NAME AND PHONE)	
PHYSICIAN:	PHONE NUMBER ()	

I hereby give permission to Myofascial Therapy to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to Myofascial Therapy. I am financially responsible for non-covered services. I hereby give permission to the therapist to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize and request any/all physicians involved in my care to release to Myofascial Therapy, 201 E. Hamilton Ave., Campbell, CA 95008, 408/376-0900, the complete history records in their possession concerning any treatment or examination rendered to me during treatment of this diagnosis.

SIGNATURE _____ DATE _____