WELCOME TO ELITE THERAPY & FITNESS

Date_____ Appt Date/Time/Therapist: _____

Patient #_____ Send reminder? ☐ e-mail ☐ text message (provider_____)

Patient Name: _____
First Middle Last

Home Address:_____
City State Zip

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Email: _____ Emergency Contact: _____
Name Phone #

Birthdate: _____ Sex: M____F____ Age:_____ Marital Status: M____S____

Social Security#:_____ Occupation: _____

DIAGNOSIS/CHIEF COMPLAINT: _____

REFERRING PHYSICAN/PHONE#:_____

Primary care physician:_____ Date of Onset: _____

How Did You Hear About Us? (Please Circle) Doctor/Internet/Friend/Other_____

INSURANCE

Is this accident related? Y/N Auto/Workers Comp IF yes, Date Of Injury:_____ State: _____

Managing Company/Address _____

Claim #_____ Adjuster Name and Phone # _____

Attorney involved? Y/N Attorney Name and Phone # _____

HAVE YOU HAD PHYSICAL, OCCUPATIONAL OR CHIROPRACTIC THERAPY THIS YEAR? Y/N
***If yes, # of visits and when?_____ Is your insurance based on the calendar year? Y/N**

PRIMARY INSURANCE

Provider Phone # from Back of Card

_____

Insurance Type/Ph# ID# GP# Subscriber Name/DOB/Relationship

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SECONDARY INSURANCE

Provider Phone # from Back of Card

_____

Insurance Type/Ph ID# GP# Subscriber Name/DOB/Relationship

Complete this section only if someone other than the patient is financially responsible:

_____

Responsible party Relationship to patient