Oakland Physical Therapy, P.C.

26850 Providence Parkway, Suite 365, Novi, MI 48374

Please Print

PATIENT INFORMATION

NAME _____ SOC. SEC. # _____

ADDRESS_____ BIRTHDATE_____ AGE _____

CITY/STATE/ZIP_____ MARITAL STATUS_____

TELEPHONE_____ E-MAIL_____ ARE YOU A RETURN PATIENT?_____

HOW WERE YOU REFERRED TO THIS FACILITY? _____

FAMILY PHYSICIAN_____ REFERRING PHYSICIAN_____

DATE LAST SEEN BY REFERRING PHYSICIAN_____ NEXT APPT DATE WITH REF PHYSICIAN_____

EMPLOYMENT INFORMATION

EMPLOYED?_____ IF RETIRED, IS SECONDARY INSURANCE COMPANY PAID? _____ OR SELF-PAID? _____

OCCUPATION_____ NAME OF EMPLOYER_____

EMPLOYER'S ADDRESS_____ CITY_____ ZIP_____ PHONE_____

SPOUSE'S EMPLOYER / ADDRESS

_____ CITY_____ ZIP_____ PHONE_____

HEALTH INSURANCE (*PLEASE COMPLETE REGARDLESS OF OTHER COVERAGES*)

1. PRIMARY INSURANCE CARRIER_____ PHONE_____

   Contract No. / S. S. No. _____Group No._____ Insured's Date of Birth_____

2. SECONDARY INSURANCE CARRIER (Coverage through Spouse Or Other Family Member)

   INSURANCE COMPANY_____ PHONE_____

   Contract No. / S. S. No._____Group No._____ Insured's Date of Birth_____

WAS INJURY DUE TO ANY TYPE OF ACCIDENT? _____ IF YES, PLEASE COMLETE THE FOLLOWING:

TYPE OF ACCIDENT: AUTO _____ WORK INJURY _____ OTHER _____

AUTOMOBILE INSURANCE INFORMATION *OR* WORKER'S COMPENSATION INSURANCE INFORMATION

NAME OF INSURANCE COMPANY_____DATE OF ACCIDENT/INJURY_____

ADDRESS_____ CITY_____ ZIP_____

CLAIM NUMBER_____CLAIM ADJUSTER_____ PHONE_____

LEGAL REPRESENTATIVE FOR THIS CASE, IF ANY_____ PHONE_____

PERSONS TO NOTIFY IN CASE OF EMERGENCY: (1) _____ PHONE_____

(2) _____ PHONE_____

Benefit information which is received from the insured's insurance company does not constitute a guarantee of claim payment. Therefore, I understand it is my responsibility to also obtain benefit coverage information from my insurance company. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature_____ Date_____

Parent (if minor) _____ Date_____