EXCEL
REHABILITATION & SPORTS THERAPY

NEW PATIENT DEMOGRAPHIC SHEET

LAST NAME:_____FIRST NAME:_____MI:_____

HOMEADDRESS_____

CITY:_____STATE:_____ZIP:_____HOME PHONE:_____

CELL PHONE:_____WORK PHONE:_____DATE OF BIRTH:____/____/____ SEX: MALE / FEMALE

SOCIAL SECURITY#_____-_____-_____ E-MAIL ADRESS:_____

EMERCENCY CONTACT:_____RELATIONSHIP:_____PHONE:_____

FAMILY PHYSICIAN:_____PHONE:_____ SPOUSE NAME_____

HOW DID YOU HERE ABOUT EXCEL REHABILITATION & SPORTS THERAPY? _____

FINANCIAL INFORMATION: (If the patient is a minor, pleases complete this information)

NAME OF RESPONSIBLE PARTY:_____RELATIONSHIP:_____

ADDRESS:_____CITY:_____

STATE:_____ZIP:_____PHONE:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:

POLICY HOLDER NAME:_____RELATIONSHIP:_____DOB:____/____/____

SECONDARY INSURANCE:

POLICY HOLDER NAME:_____RELATIONSHIP:_____DOB____/____/_____

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered, regardless of my insurance. I have read all the information above and certify this information is true and correct to the best of my knowledge. I will notify EXCEL REHABILITION & SPORTS THERAPY of any changes in my status or the above information. I herby authorize any treatment(s) agreed upon with the Physical Therapist and my referring physician which are deemed medically necessary.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I also authorize EXCEL REHABILITAITON & SPORTS THERAPY and its staff to call my home and leave messages regarding appointment with my spouse and/or answering machine. Furthermore, I authorize the use of facsimile transmission, e-mail transmission, internet transmission, and electronic transmission of my personal health information for the purpose of treatment, payment and healthcare operations.

*PATIENT OR RESPONSIBLE PARTY SIGNATURE:*_____*DATE:*_____