

Atlas Physical Therapy, P.C.

Patient Demographics Form

Date: _____

Patient Name _____ Social Security Number _____

Sex: Male Female Date of Birth _____ Age _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____

Cell Phone: _____

Marital Status: Single Married Divorced Separated Widowed

Student Status: FT PT non-student

Employer _____

Address _____

City/State/ Zip _____

Referring Physician's Name _____ Phone Number _____

RESPONSIBLE PARTY

Name of person responsible for account _____

Relationship to the patient: self spouse parent other

Address (if different from above) _____

City/State/Zip _____ Phone # _____

Date of Birth _____ SSN# _____

Emergency Contact _____ Phone# _____

Is this condition the result of an accident? Yes No

If Yes, is this _____ Workmen's Comp. _____ Auto

If No, please go to Primary Insurance Company

Date of Accident _____ Claim # _____ Adjuster's Name _____

Name and Address of Insurance Company _____

Phone Number _____

Have you retained a lawyer for this accident? Yes No

If yes, Name of Attorney _____ Phone Number _____

Attorney Address _____

Primary Insurance Information

Insurance Company Name and Address _____

ID/Policy # _____ Group # _____

Secondary Insurance (or Health Insurance if accident)

Insurance Company Name and Address _____

ID/Policy# _____ Group# _____

Please briefly describe the nature of your injury, illness or pain:
