ATLAS
PHYSICAL THERAPY

One-on-One Care
That Gets Results

Patient Name: _____ Date: _____

Social Security Number: _____

Date of Birth: _____ Age: _____

Sex (circle): Male Female

I give permission for Atlas Physical Therapy to email me. Yes No Email Address: _____
I give permission for Atlas Physical Therapy to text me. Yes No Cell Phone: _____

Home Phone: _____
Which phone number do you prefer we use to contact you? Cell Home

Address: _____
City/State/Zip: _____

Marital Status (circle): Single Married Divorced Separated Widowed
Student Status (circle): FT PT Non-Student
Employer: _____
Address: _____
City/State/Zip: _____

Emergency Contact: _____ Phone: _____
Referring Physician: _____ Phone: _____

Name of Person Responsible for Insurance Account: _____
Relationship to the patient (circle): Self Spouse Parent Other
Address (if different from above): _____
City/State/Zip: _____ Phone: _____
Date of Birth: _____ Social Security Number: _____

Is this condition the result of an accident: Yes No
If YES, is this: Workman's Comp Auto If NO, go to Primary Insurance
Date of Accident: _____ Claim #: _____
Adjuster's Name: _____ Phone Number: _____
Name/Address of Insurance Company: _____

Have you retained an attorney for this accident? Yes No
If Yes, Attorney Name: _____ Phone: _____
Attorney Address: _____
_____

Primary Insurance Name: _____
ID/ Policy #: _____ Group #: _____
Secondary Insurance Name: _____
ID/Policy #: _____ Group #: _____

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

_____
_____
_____
_____