Welcome To

PERFORMANCE THERAPY

Please take a few moments to complete this form in its entirety. All information will be considered confidential and will be released only as allowed through HIPPAA regulations and as considered necessary for treatment, payment or other health care questions.

PATIENT INFORMATION

First Name	**MI**	**Last Name**	
Address			
City	**State**	**Zip**	
Home Phone	**Cell Phone**	**Work Phone**	
Date of Birth	**Current Age**	**SSN**	**Sex**
Marital Status (Circle One)	**Minor**	**Single**	**Married** **Divorced** **Widowed** **Separated**
Employer	**Employer Address**		
City	**State**	**Zip Code**	
Emergency Contact		**Daytime Phone**	
Primary Care Physician:			
Accident Related Yes No	**Type: Auto Work Other**	**Date of Injury:**	
How Did This Injury Occur?			
Doctor / Attorney:			
If Work Related: Case Worker's Name		**Phone**	
Who Can We Thank For Your Referral?			

RESPONSIBLE PARTY/ GUARANTOR INFORMATION

Name of person responsible for this account			
Relationship to patient	**Daytime Phone**	**Home Phone**	
Address	**City**	**State**	**Zip**
Employer		**Employer Phone**	

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Phone	**Phone**
Policy ID#	**Policy ID#**
Group#	**Group#**
Insured Name	**Insured Name**
Relationship to Patient	**Relationship to Patient**
Date of Birth	**Date of Birth**
SSN	**SSN**
Insured's Employer	**Insured's Employer**
Phone	**Phone**

PATIENT SIGNATURE_____ **DATE**_____

*A $50.00 charge will be given to cancellations when less than 24 hours notice is given