Putnam Physical Therapy Services

Patient Information

Full Legal Name: _____

Address: _____ City and Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ **Email**: _____

Date of Birth: _____ Age: _____

Marital Status: Married __ Single __ Divorced __ Widowed __

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referring Physician: _____ Next scheduled appt: ___/___/___ No appt schd __

How did you hear about us? _____

Are you currently receiving home health services or have you within the last 4 weeks? __Yes __ No

Have you had any physical, occupational or speech therapy this calendar year? __ Yes __ No

Insurance (copy of card will be on file)

Primary Carrier: _____ Subscriber #: _____

Name of Insured: _____ Insured's Employer: _____

Insured's Date of Birth: _____ Insured's Social Security # : _____

Relationship of Patient to Insured: Self __ Spouse __ Child __ Other __

Secondary Carrier: _____ Subscriber # _____

Who is responsible for payment of medical bills? _____

Vehicle Accident (if applicable)

Date of Injury: _____ Claim #: _____ Insuranc Co: _____

Insurance Contact: _____ Contact #: _____

Billing Address: _____

Note: Putnam Physical Therapy Services provides free insurance billing services for our patients. We require patients to make regular payments for charges not covered by insurance (exception: workers' compensation). Our office manager will be happy to set up a payment plan to work within your budget. **Initial:** _____

Assignment of Insurance Payments

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Putnam Physical Therapy Services, 1140 Perimeter Park Drive, Cookeville, TN for services furnished and to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ Date: _____