PATIENT ADMISSION FORM

Account number: ______________________________ Appointment Date: _______________________

Chart Number: ________________________________ Physical Therapist: ________________________________

Referring Physician: ________________________________ Phone #: ________- _________-________

Referring Physician NPI#: ____________________________ Fax #: ________ - _________ - _________

For Office Use Only

DATE _______________

HOME PHONE # _____________________ CELL PHONE # ___________________ OTHER PHONE # _____________

NAME ____ SOCIAL SECURITY # _______________________________

MAILING ADDRESS ___________________________ CITY __________________ STATE ________ZIP ___________

BIRTH DATE ________________________ AGE _________ STATUS (circle one): S M W D SEX (circle one) M F

SPOUSE'S NAME ______________________________ SPOUSE'S S.S.# ____________________ D.O.B.__________

MAJOR COMPLAINT/DIAGNOSIS ____

DATE OF ACCIDENT/INJURY __________________________ TYPE (circle one): WORKER'S COMP AUTO OTHER

EMERGENCY CONTACT ___________________________________ PHONE # _______________________________

EMPLOYER NAME____

EMPLOYER ADDRESS ____

EMPLOYER PHONE ____

NEXT DOCTOR'S APPOINTMENT (date) ____________________________________

PRIMARY INSURANCE ____ POLICY ID # __________________________

POLICY HOLDER ____ POLICY HOLDER S.S.# ______________________

SECONDARY INSURANCE ____ POLICY ID # __________________________

POLICY HOLDER ____ POLICY HOLDER S.S.# ______________________

Have you received any physical therapy services this year? (circle one) Y N If yes, how many visits? ______________
Who is responsible for this bill? ____
Will you be paying by (circle one) CASH CHECK CREDIT CARD

I acknowledge the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of treatment. I irrevocably assign all benefits to LSU-HSC Physical Therapy Clinic. I authorize release of medical records to my doctor and insurance company. If my reason for seeking treatment is the result of a work-related or personal injury claim, I also release information to my attorney, claims adjustor and my employer. I also authorize any physician or medical facility to release information relevant to LSU-HSC Physical Therapy Clinic. I understand and agree that (regarding my insurance status), I am ultimately responsible for the balance of my account for any professional services.

PATIENT'S SIGNATURE: ____ DATE ________________________