Orthopedic Physical Therapy of Northern Virginia, Ltd.

Patient Information Form

Date _____

Patient # _____

(PLEASE PRINT)

PERSONAL INFORMATION: STATUS: SINGLE _____ MARRIED _____ WIDOWED_____ IF STUDENT: F/T _____ P/T _____

NAME _____
LAST FIRST M.I.

ADDRESS _____
STREET APT # CITY STATE ZIP CODE

_____ _____
HOME PHONE WORK PHONE

_____ Do you wish to receive TEXT reminders? YES ____ NO _____
CELL PHONE

If yes, what is your cell phone provider _____

_____ Email reminders? YES ____ NO _____
E-MAIL ADDRESS

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____ AGE _____SEX _____

EMPLOYER or SCHOOL: _____ OCCUPATION: _____

ADDRESS_____
STREET SUITE# CITY STATE ZIP CODE

IN CASE OF AN EMERGENCY CONTACT: _____

PHONE _____ RELATIONSHIP_____

INSURANCE:

_____ _____ SOCIAL SECURITY # _____-_____-_____
Subscriber's NAME DATE OF BIRTH

Is condition due to an accident? Yes _____ No _____

If yes, please explain:_____

_____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that I am responsible for any additional charges that would be incurred if my account has to be turned over for collection. I have read the HIPAA Privacy Notice provided. I will notify you of any changes in my health status or the above information.

IT IS ALSO MY RESPONSIBILITY TO BE AWARE OF MY OWN INSURANCE COVERAGE, GUIDELINES, AND LIMITATIONS.

"I also authorize the release of information acquired in the course of my treatments to the physician and to qualified agencies."

SIGNATURE _____DATE _____

PARENT (if minor) _____ DATE _____