SPINE & SPORT
PHYSICAL THERAPY

JODY B. RAWLINGS PT, DPT
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PATIENT INFORMATION

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Name_____
Address_____
City_____ State_____ Zip_____
Date of Birth(mm/dd/yy)_____ Sex ☐M ☐F
Social Security Number_____
Home Phone_____ Cell Phone_____
Occupation_____
Employer_____

Referring Physician_____
Address_____
City_____ State_____ Zip_____

Is this accident related?☐Y ☐N If yes, is it work comp?☐Y ☐N
Date of Injury_____ Claim Number_____
Responsible Insurance_____
Adjuster Name:_____

INSURANCE INFORMATION

Primary_____
Address_____
City_____ State_____ Zip_____
Subscriber's Name_____
Subscriber Date of Birth (mm/dd/yy)_____
ID Number_____
Group Number_____

Secondary_____
Address_____
City_____ State_____ Zip_____
Subscriber's Name_____
Subscriber Date of Birth (mm/dd/yy)_____
ID Number_____
Group Number_____

INFORMATION NEEDED FOR TREATMENT OF A MINOR

Father's Name_____
Address_____
City_____ State_____ Zip_____
Social Security Number_____
Date of Birth (mm/dd/yy)_____
Employer_____
Work Phone_____ Cell Phone_____

Mothers Name_____
Address_____
City_____ State_____ Zip_____
Social Security Number_____
Date of Birth (mm/dd/yy)_____
Employer_____
Work Phone_____ Cell Phone_____

IF MARRIED

Spouse's Name_____
Employer_____
Work Phone_____
Cell Phone_____
Social Security Number_____
Date of Birth (mm/dd/yy)_____

EMERGENCY INFORMATION

Relative or Friend not living with you
Name_____
Address_____
City_____ State_____ Zip_____
Work Phone_____ Cell Phone_____

I authorize Spine and Sport Physical Therapy to release medical record to designated insurance companies to facilitate payment of authorized benefits. Under all circumstances I assume final responsibility for my account. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Spine and Sport Physical Therapy for services rendered.

Date_____**Signature**_____