



ASHLAND PHYSICAL THERAPY

Orthopedic and Sports Physical Therapy

Patient Information		Today's Date: / /	
First Name	Last Name	M.I.	Age
Address	City	State	Zip
Birth Date / /	SS# - -	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone () -	Cell Phone () -	
Email:			
Chose Clinic Because <input type="checkbox"/> Dr. Referred <input type="checkbox"/> Friend/Family Referred <input type="checkbox"/> Website <input type="checkbox"/> Insurance Plan			
<input type="checkbox"/> Return Patient <input type="checkbox"/> Advertisement <input type="checkbox"/> Location			
Work Information			
Employer	Work Phone () -	Ext.	
Occupation	Employment Status <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed		
School Information			
Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No	School Name:		
Did you get hurt at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Playing what sport:		
Physician Information			
Referring Doctor	Family Doctor		
Can we share your records with your family doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance Information			
Primary Insurance Name	Secondary Insurance Name		
Subscriber Name	Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent		
Subscriber Date of Birth / /	Subscriber SSN: - -		
In Case of Emergency			
Name of local friend or relative	Relationship		
Home Phone () -	Work Phone () -		
Financially Responsible Party (if patient is a minor please make sure to fill in all information)			
Name	Date of Birth / /	SS# - -	
A laminated copy of our Notices of Privacy Practices is available for you to read in our lobby. We are more than happy to provide you with a copy for you to take with you. Just ask the receptionist.			
Our Notice Of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. I, _____ (please print patient name) have reviewed a copy of Richmond Physical Therapy's Notice of Privacy Practices. I understand that I may ask questions to Richmond Physical Therapy if I do not understand any information contained in the Notice of Privacy Practices.			
Patient/Guardian Signature _____		Date _____	

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