



# RICHMOND PHYSICAL THERAPY

*Orthopedic and Sports Physical Therapy*

Patient Information		Today's Date: / /	
First Name	Last Name	M.I.	Age
Address		Apartment#	
City	State	Zip	
Birth Date / /	SS# - -	Marital Status <u>  </u> S <u>  </u> M <u>  </u> W	
<u>  </u> Male <u>  </u> Female	Home Phone ( ) -	Cell Phone ( ) -	
Email:			
Chose Clinic Because <u>  </u> Dr. Referred <u>  </u> Friend/Family Referred <u>  </u> Website <u>  </u> Insurance Plan			
<u>  </u> Return Patient <u>  </u> Advertisement <u>  </u> Location <u>  </u> Social Media			
Work Information			
Employer	Work Phone ( ) -	Ext.	
Occupation	Employment Status <u>  </u> Full <u>  </u> Part <u>  </u> Retired <u>  </u> Not Employed		
School Information			
Are you a student? <u>  </u> Yes <u>  </u> No	School Name:		
Did you get hurt at school? <u>  </u> Yes <u>  </u> No	Playing what sport:		
Physician Information			
Referring Doctor	Family Doctor		
Can we share your records with your family doctor? <u>  </u> Yes <u>  </u> No			
Insurance Information			
Subscriber Name	Relationship to patient <u>  </u> self <u>  </u> spouse <u>  </u> parent		
Subscriber Date of Birth / /	Subscriber SSN: - -		
In Case of Emergency			
Name of local friend or relative	Relationship		
Home Phone ( ) -	Work Phone ( ) -		
Additional Questions			
Date of Injury/ Onset Date: _____ Auto Related?: <u>  </u> Yes <u>  </u> No If Yes-State? _____			
Work Related: <u>  </u> Yes <u>  </u> No Post Surgical: <u>  </u> Yes <u>  </u> No <u>  </u> Unknown Surgery Date: _____			
If Work or Auto Related: Adjuster name: _____ Phone #: _____			
Have you had any prior Therapy this year? (PT/OT/ST or Chiropractic) <u>  </u> Yes <u>  </u> No			
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 <b>Notices of Privacy Practices</b> 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.			
<b>Our Notice Of Privacy Practices provides information about how we may use and disclose medical information about you.</b>			
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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