



ALLIANT
PHYSICAL THERAPY GROUP

Clinic: _____

PATIENT INFORMATION

TODAY'S DATE: _____

NAME: _____ MALE FEMALE
(LAST) (FIRST) (M.I.)

ADDRESS: _____
(CITY) (STATE) (ZIP CODE)

BIRTHDATE: ____/____/____ AGE: ____ SOCIAL SECURITY NUMBER: ____/____/____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ *E-MAIL: _____

EMPLOYER: _____

ARE WE BILLING: WORK COMP INS. PERSONAL INS. MOTOR VEHICLE INS.

INJURY DATE: ____/____/____ AUTO ACCIDENT: YES NO WORK RELATED: YES NO

NAME OF PRIMARY INSURANCE: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: ____/____/____ BIRTHDATE: ____/____/____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY INSURANCE or ATTORNEY: _____

INSURANCE CONTACT PERSON: _____ PHONE: _____

Referred by: _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE: _____

AUTHORIZATION FOR TREATMENT: I give my consent to undergo examination and treatment by the staff at **Alliant Physical Therapy**.

PATIENT SIGNATURE: _____ DATE: _____

AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS

I authorize the release of any information required to act on this claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original. I hereby assign to **Chad Novasic PT., LTD.**, doing business as **Alliant**, the medical benefits I am entitled to for Physical Therapy services from my insurance company. I understand **I am responsible for any charges** not paid for by my insurance company. *By listing my email address I authorize Alliant Physical Therapy Group to send emails to me.

PATIENT SIGNATURE: _____ DATE: _____

