



## Welcome to Pantops Physical Therapy & Occupational Therapy!

### Patient Information:

Name: \_\_\_\_\_  
                    First                    Last                    Middle

Mailing address: \_\_\_\_\_

\_\_\_\_\_  
                    City                    State                    ZIP code

Email Address: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

### Billing Information:

Responsible Party: \_\_\_\_\_  
                                    First Name                    Last Name

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

### Social History:

Do you live alone? Yes No

Distance from nearest independent relative/caregiver: \_\_\_\_\_

Have you fallen in the past year? Yes No

If yes, how many times? \_\_\_\_\_

Were you able to return to standing independently? Yes No

Do you ascend/descend stairs? Yes No

If yes, do you require a rail? Yes No

### Referral Information:

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Other physicians: \_\_\_\_\_

How did you hear about our services? M.D. \_\_\_\_\_ Friend: \_\_\_\_\_

Phone Book: \_\_\_\_\_ Other: \_\_\_\_\_

We e-mail our patients for quarterly newsletters and birthday cards. May we e-mail you? Y N

Date: \_\_\_\_\_

Home telephone(\_\_\_\_) \_\_\_\_\_

Work telephone(\_\_\_\_) \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Marital Status: M D S

Occupation: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Social Security Number of Insured: \_\_\_\_\_

Patient's Relationship to Subscriber: \_\_\_\_\_