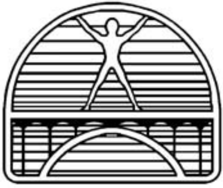

FOLSOM PHYSICAL THERAPY

and Training Center

(WC) Patient Information

Name: ______________________ Last 4 digits SS__________ DOB:__________ Cell Phone:__________________

Address:______________________ City:________________ Zip: __________ Home Phone:__________________

Emergency Contact:__________________________ Phone:______________ Relationship: ________________

Employer Information (at time of injury)

Employer:__________________________ Contact person:________________ Phone#:______________

Address:________________ City:__________________ Zip:__________ Date of Onset/Injury:____________

Diagnosis: ____________________ Current Employer:______________________ Work#:______________

Referring M.D.

Name:__________________________ Phone:______________________ Fax:________________

Address:__________________________ City:______________________ Zip: ________________

Next MD Appointment:

Worker's Compensation Carrier Information

Insurance Company:____ Claim#:__________________

Address:__________________________________ City: __________________ Zip:________________

Adjustor:_________________________________ Phone:__________________ Fax#:________________

[FOR OFFICE USE ONLY] **ICD-9 Code: Therapist**

Rx Date	Freq/Duration	Authorized By	*Valid Dates*	#Visits Total	Comments