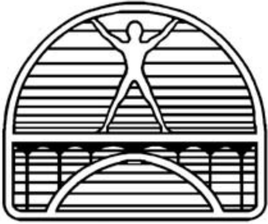

FOLSOM PHYSICAL THERAPY
and Training Center

Patient Information

Chart #: __________

Date: __________

Name:________________________________ Last 4 digits SS:________ DOB: ________ Cell Phone:________________

Address:________________________ City: ____________________ Zip:_________ Home Phone:________________

Email Address:____________________Employer: ___________________________Work Phone: ______________

Emergency Contact: ____________________________Phone: ___________________Relationship:________________

Date of Onset/Injury: ____Diagnosis: ____________________________

Referring M.D.

Name:_____________________________________Phone:___________________ Fax:____________________

Address:____________________________________ City:__________________________ Zip:_______________

Next MD Appointment:____

Insurance Company Info

Insurance Company:____Phone:_________________

Address:____Policy ID#:____________________________

City:_________________________________ State:________ Zip:______________Group#:__________________

[FOR OFFICE USE ONLY]

Insurance: PPO ____ Medicare ____Self Pay ____Auto __ Lien____ **ICD-9 Code**: ____ **Therapist:**_________

Rx Date	Freq/Duration	Date	*Verified By*	Benefits/Coverage
				Effective:
				Deductible: Met:
				Co-Pay: Co-Ins:
				Reimbursement:
				Out-of-Pocket:
				Limitations:
				Rx required: ☐ **YES** ☐ **NO**