HANDS ON
PHYSICAL THERAPY, PC

147 SW Shevlin Hixon Drive Suite 104 ĀBend, Oregon 97702
TEL: 541.312.2252 ĀFax: 541.312.8822

PATIENT INFORMATION

Name: _____ Todayôs Date:_____
Last Name First Name MI

Address: _____ City: _____State: _____Zip:_____

Date of Birth:_____ Age: ____ Male: ___ Female:___ Social Security #:_____

Home Phone #: ( )_____ Cell Phone #: ( )_____

Please circle your preference for appointment reminders: Text Message E-mail Home Phone

Cell Phone Carrier (for text message reminders): _____

E-mail (include if you would like our quarterly newsletter and updates): _____

Occupation:_____

Patient Employer/School _____ Employer/School Phone ( ) _____

How did you hear about us? _____Friend/Family Member _____Doctor _____Website _____Phonebook

Whom May We Thank for Referring You? _____

Emergency Contact Information:

Name:_____ Relationship:_____

Home Phone#: ( ) _____ Work Phone#: ( ) _____ Cell Phone#: ( )_____

INSURANCE INFORMATION

Name of Subscriber _____

Subscriberôs Date of Birth _____ Relationship to Patient_____

Is Patient Covered by Additional Insurance? ____ Yes ____ No

ACCIDENT/INJURY INFORMATION

Is your injury due to: On-the-job injury? ____YES ____NO Motor vehicle accident? ____YES ____NO

If you answered ñYESò to either of the above, please complete the following:

Date of Accident: _____

Insurance Company: _____ Adjusterôs Name:_____

Phone #: ( )_____ Claim #:_____

Address:_____
Street City State Zip