

CLIENT INFORMATION

NAME _____ AGE _____ BIRTHDATE _____ HT _____ WT _____ SEX _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
Phone: Home _____ Work _____ Ext _____ Cell _____
Email: _____ PROFESSION _____

MARITAL STATUS: S M W D Sep. Spouse's Name _____
YOUR SOC. SEC.# _____ - _____ - _____ SPOUSE'S SOC. SEC.# _____ - _____ - _____

HOW did you hear about our services? _____

INSURANCE INFORMATION:

InsuranceCo.Name _____ Phone _____
Ins.Co.Address _____ Zip _____
Policy# _____ Group# _____ Plan# _____
Insured's Name _____ Ins.Claims-person _____
Insured's Employer _____

DO YOU HAVE SECONDARY INSURANCE? []YES []NO If yes, please complete the following:

Second Ins.Co.Name _____ Phone _____ Ext. _____
Ins.Co.Address _____ Zip _____
Policy# _____ Group# _____ Plan# _____
Insured's Name _____ Ins.Claims-person _____
Insured's Employer _____

DOCTORS' NAMES(1) _____ (2) _____
Addresses _____
Phone# _____ Phone# _____

YOU ARE SEEING US DUE TO WHICH OF THE FOLLOWING? (Please give dates and kind of problems.)

ACCIDENT INJURY ILLNESS SURGERY CHRONIC PROBLEM

Explain: _____

If this is a Chronic Problem (more than 1 year old) give date of most recent flare-up: _____

WERE YOU INJURED ON THE JOB? []Yes []No IN AN AUTO ACCIDENT? []Yes []No

IS THIS A WORKERS' COMPENSATION CLAIM? []Yes []No If yes, give claim# and Claims-person:

Claim# _____ Claims-person _____

IS AN ATTORNEY INVOLVED IN YOUR CASE? []Yes []No If yes, give name, address & phone#:

Attorney's Name _____ Phone# _____
Address _____ Zip _____

PLEASE GIVE NAMES OF ANY OTHER HEALTH CARE PROFESSIONALS YOU ARE SEEING (Massage, Psychologist, Chiropractor, Acupuncture, etc.): _____

RESPONSIBLE PARTY (who will be responsible for paying the bill?)

Name _____ Relationship To You _____
Address _____ Zip _____
HomePhone# _____ WorkPhone# _____ Ext _____

I understand that each visit is to be paid for at the time of the visit, unless prior arrangements have been made. I also understand that no one will be denied medical care if they do not have sufficient funds at the time of the visit. However, payment for such visits is expected to be fulfilled within 30 (thirty) days of the visit. A late fee may be charged on overdue account balances.

I understand that I will be charged for an appointment which I miss and do not cancel before 8AM of the day PREVIOUS to my scheduled appointment.

I have read the two statements above, and I understand them. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed _____ Date _____

(FOR OFFICE USE ONLY) Special Billing Arrangements/Deductible/ETC. _____