



PATIENT INFORMATION

Today's Date: _____ (PLEASE PRINT)

Name _____ Soc. Sec.# _____ - _____ - _____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Single Married Widowed Separated Divorced Student / Grade Level: _____ Sex M F

Birth date _____ Age _____ Home Phone Number: () _____ - _____ Email address _____

Advance Directive: Yes No (if "Yes" please provide a copy of your Advance Directive for your clinic chart)

Date of onset of Symptoms / Chief Complaint: _____

Patient Employed by _____ Occupation _____

Employers Address _____ Employers Phone Number () _____ - _____

Referring Physicians Name _____ Date to return to Physician: _____ / _____ / _____

How did you hear about Excel Physical Therapy & Sports Medicine Clinic? _____

Have you had any previous physical therapy or chiropractic treatments this year? _____

In case of emergency who should be notified? _____ Phone () _____ - _____
Name Relation to Patient

PRIMARY INSURANCE

Name of Insurance Company _____ Insurance I.D.# _____ Group# _____

Policy Effective Date ____ / ____ / ____ Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec.# _____ - _____ - _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible is Employed by _____ Occupation _____

Employers Address _____ Employers Phone _____

SECONDARY / ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Name of Insurance Company _____ Soc. Sec.# _____ - _____ - _____

Insurance ID # _____ Group # _____ Effective Date of Policy ____ / ____ / ____