



Label & Associates
physical therapy

Confidential Patient Information

Name _____ D.O.B. ____ - ____ - ____ Age ____
 Address _____ Apt _____ Phone ____ - ____ - ____
 City _____ State ____ Zip ____ Sex Male Female
 E-Mail _____ Cell # ____ - ____ - ____
 If minor, parent/guardian name _____ D.O.B. ____ - ____ - ____
 Insurance Subscriber _____ D.O.B. ____ - ____ - ____

Employer _____ Phone ____ - ____ - ____
 Address _____ Ext or Dept _____
 City _____ State ____ Zip ____ Hours _____
 Occupation _____ Supervisor _____

Spouse _____ D.O.B. ____ - ____ - ____
 Employer _____ Phone ____ - ____ - ____
 Address _____ Work ____ - ____ - ____
 City _____ State ____ Zip ____

Emergency Contact _____ Relationship _____
 Address _____ Phone ____ - ____ - ____
 City _____ State ____ Zip ____

Referring Physician _____ Next Visit ____ - ____ - ____
 Primary Care Physician _____ Next Visit ____ - ____ - ____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** ____ - ____ - ____