JOHNSON PHYSICAL THERAPY
& REHABILITATION PC

Please complete *ALL* of the following. Please print clearly.

Today s Date:_____

Name:_____
first middle initial last
Address:_____
City:_____ State:_____ Zip:_____
Phone: (home)_____(work)_____ (cell) Phone:_____
Email_____

REMINDER CALL PREFERENCE - ☐ email ☐ Voice ☐ Text

Date of Birth:_____ SS# :_____
(we need SSN for BILLING reasons)
Marital Status: **S M D W** Student: **NO YES** - ***part time*** or ***full time***
Employer:_____ are you: **Part Time** or **Full Time**
If ***NOT*** working, are you: **Retired** or **Disabled**

Referring Doctor:_____ Primary Doctor:_____

What type of injury / problem are we seeing you for:_____
_____
Have you had Surgery, for this injury/problem: **Y N** If **YES**, give date:_____

Name of Insurance:_____
Primary policy holder:_____ Primary 's DOB:_____

Was this a result of an **Auto Accident**: **Y / N** If **YES**, give date:_____
Was this a result of a **Workman's Comp Injury**: **Y / N** If **YES**, give date:_____
Name and Address of Employer_____
Claim# or Case#:_____ Adjustor:_____

MEDICARE PATIENTS:

Are you **now** currently or **have you had** *ANY* **HOME HEALTH** services in the last **6 months**, for this injury or any other problems (if **YES**, please describe)_____
_____

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Who can we contact in case of an **Emergency**:_____
Phone:_____ Relationship:_____