PINNACLE
PHYSICAL THERAPY

PATIENT PERSONAL INFORMATION

Name (Last)_____**(First)**_____

SSN _____ **Marital Status**_____ **Sex**_____

Home address _____ **City** _____ **State** ____ **Zip** _____

Home Telephone _____**Work Telephone** _____**Mobile Telephone**_____

Date of birth _____**Email Address**_____

Appointment Reminder Preference: Cell Voice / Cell Text / Home Voice / Email

Person to contact in case of emergency _____

Relationship _____ **Telephone** _____

Referring Physician _____ **Telephone** _____

Diagnosis _____ **Date of Referral** _____

How did you hear about Pinnacle Physical Therapy? _____

NAME OF PRIMARY INSURED/POLICY HOLDER

Name _____ **Relationship To Patient** _____**DOB**_____

Employer Name _____ **Telephone** _____

INSURANCE INFORMATION – [Office Use Only]

INSURANCE: [ ]PRIVATE [ ]AUTO [ ] MEDICARE [ ]CASH [ ]WORKERS COMP [ ]OTHER: _____

Primary

Name of Insurance Company _____**Telephone**_____

Policy ID # _____ **Group/Claim #** _____

Effective Date of Ins. Coverage _____ **Deductible** _____ **Met** _____ **Co-pay** _____

Benefits _____**% Out of Pocket Pay** _____**% Plan Limitations** _____

Max Visits/Dollar _____ **Date** _____ **# of Visits Authorized** _____

Secondary

Name of Insurance Company_____**Telephone**_____

Policy Holder_____**Relationship to Patient**_____