Patient Information

HOLDREGE PT
PHYSICAL THERAPY & SPORTS REHAB

Name: ____ Middle Initial: _____ Today's date: ____________________

Home Address: ____

PO Box: ______________ City: _________________________________ State: _______ Zip: _________________________

Patient's date of birth: ______________________ Patient's SSN: _________ - ______ - _________

Age: _______ Male ☐ Female ☐ Appointment reminder by: ☐ text? ☐ voice message? ☐ email?

Cell phone: ___________ - ___________ - ___________ Home phone: ___________ - ___________ - ___________

Work phone: ___________ - ___________ - ___________ Email: ____

Responsible Party (if different from Patient): _______________________________________ Date of birth: ______________

Address: ____

Phone: ___________ - ___________ - ___________ SSN (required): _________ - ______ - _________

Emergency Contact: ____ Relationship: ______________________

Phone: ___________ - ___________ - ___________

Have you had any other therapy in the past year? ☐ Physical Therapy ☐ Occupational therapy ☐ Speech Therapy

Is this current concern/complaint the result of an accident? Y N ☐ work ☐ auto ☐ other

Date of onset of pain/injury/incident: ____

Brief summary of the cause of pain/injury/incident: ____

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Primary Insurance Provider: ☐ Medicare ☐ BCBS ☐ Aetna ☐ Arbor ☐ Coventry ☐ Midlands Choice ☐ United Healthcare ☐ Work Comp Other: ________________________________

Policy Holders Name: _______________________________ Policy Holder's date of birth: ____________________

Policy Holder's SSN: _________ - _________ - _________ Insurance ID #: ________________________________

Secondary Insurance Provider: ☐ Medicare ☐ BCBS ☐ Aetna ☐ Arbor ☐ Coventry ☐ Midlands Choice ☐ United Healthcare ☐ Work Comp Other: ________________________________

Policy Holders Name: ______________________________ Policy Holder's date of birth: ____________________

Policy Holder's SSN: _________ - _________ - _________ Insurance ID #: _________________________________

Referring Physician: ____

☐ **My provider REQUIRES pre-authorization**

☐ **My provider DOES NOT require pre-authorization**

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Patient or Parent/Legal Guardian's Signature