



RESILIENCE

PHYSICAL THERAPY AND WELLNESS

Patient Information

Please complete all the information below in order for us to serve you better.

PATIENT INFORMATION	
Patient Name _____	Employer _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Cell Phone _____	Phone _____
Home Phone _____	Emergency Contact _____
Email _____	Phone _____
Date of Birth _____	

Date of Injury _____	Referring Physician _____
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RESPONSIBLE PARTY (please complete if different from patient)	
Name _____	Employer _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone _____	Phone _____
Social Security # _____	

INSURANCE INFORMATION <i>If patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you.</i>	
Primary Insurance _____	Secondary Insurance _____
Group # _____	Group # _____
Policy # _____	Policy # _____
Relationship to Patient _____	Relationship to Patient _____
Insurance Phone # _____	Insurance Phone # _____
Medicare # _____	
Medicaid # _____	
Date of Birth _____	

Please provide your insurance card and identification so a copy can be made for your file. Verification of benefits is not a guarantee of payment. Patient is ultimately responsible for account balance.

Patient Signature _____ **Date** _____