# Evolve Physical Therapy and Sports Center

## PATIENT INFORMATION SHEET

**(Please Complete In Full)**

**PATIENTS INFORMATION**

NAME. ________________________________ **TODAY S DATE.** ____________
(Last) (First) (Middle)

E-MAIL ADDRESS: ________________________________

ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

HOME PHONE: ____________ ALT. PHONE (specify): ____________ DRIVERS LICENSE: ____________

BIRTH DATE: ____________ SOCIAL SECURITY NO.: ____________ ☐ Male ☐ Female AGE: ______

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

EMPLOYER: ____________ WORK PHONE: ____________

EMPLOYER'S ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

NAME of **SPOUSE or PARENT** (circle one): ____________ DOB: ____________ S.S.# ____________

EMPLOYER of Spouse or Parent: ____________ WORK PHONE: ____________

EMPLOYER'S ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

**EMERGENCY CONTACT INFORMATION**

EMERGENCY CONTACT (not living in same household): ____________ PHONE 1 - ____________

RELATION TO PATIENT: ____________ PHONE 2- ____________

**INSURANCE INFORMATION**

**DATE OF INJURY:** ____________

**PRIMARY INSURANCE CO.:** ____________

NAME of Policyholder: ____________

DOB of Policyholder: ____________ S.S. # ____________ RELATION TO PATIENT: ____________

**SECONDARY INSURANCE CO.:** ____________

☐ Check if information is same as primary insurance

NAME of Policyholder: ____________

DOB of Policyholder: ____________ S.S. # ____________ RELATION TO PATIENT: ____________

**How were you referred to Evolve Physical Therapy?**

Primary Care Physician: ____________ CITY: ____________ Phone #- ____________

Referring Physician: ____________ CITY: ____________ Phone #- ____________

OTHER (Please mark all that apply): ____________ ☐ Patient (please name) ____________

☐ Friend/Co-Worker ☐ Family Member ☐ PPO/HMO Directory ☐ Newspaper ☐ South Austin Physician Referral

☐ Hospital/Emergency Room ☐ Yellow Pages/SWB ☐ Yellow Pages/Austin Metro ☐ Website ☐ Our sign

**AUTHORIZATION**

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representative, or referring physician, at such time as information is requested. I authorize assignment of benefits to my physician.

CONSENT FOR TREATMENT:

I do hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

____________________________ ____________________________
Patient's Signature Date Guardian's Signature Date