SYMMETRY
PHYSICAL THERAPY

PATIENT DATA SHEET

Appointment Date ____/____/_____ Appointment Time _____

PATIENT INFORMATION

Social Security #: _____ Date of Birth: ____/____/_____ Sex: □M □ F

Name: (Last) _____ (First)_____ (MI)_____ Marital Status: □ M □ S □ W □ D

Address: _____ Home Phone: (_____) _____ - _____ Primary # Y/N

City: _____ State: _____ Zip: _____ Work Phone: (_____) _____ - _____ Primary # Y/N

Cell Phone: (_____) _____ - _____ Primary # Y/N

May we leave medical information on voice mail at your primary phone number? Y / N

Email address: _____

Employer: _____ Occupation: _____

How did you hear about our facility? _____

Emergency Contact: _____ Emergency Contact Phone: (_____) _____ - _____
Relation to Patient: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Physician Phone: (____) _____

Physician Address: _____ Prescription Date: _____

Diagnosis Code(s): _____ Specific # of Visits Requested? _____ Body Part(s): _____

RESPONSIBLE PARTY INFORMATION

Insured Person's Name: _____ Date of Birth: ____/____/_____ Sex: □ M □ F

Relation to Patient: Self Spouse Parent Other

ACCIDENT / INJURY / ONSET - INFORMATION

Previous surgeryfor this body part? □ Yes □ No Date: _____ Accident/Injury/Onset Date: ____/____/_____
(please use exact date of injury for auto or work)

Accident type: (circle) None / Work /Auto / Other (accident due to other than auto or work)

Accident details: _____
If an accident, please include where and how accident happened; if non-accident, include reason for visit.)

If an accident, State where accident occurred? _____ Check if accident was "NO FAULT" □ (no potential liable party)

INSURANCE INFORMATION Verification Phone: (_____) _____ - _____

Payer Name: _____ Claim Phone: (_____) _____ - _____ ext _____

Policy/Claim #: _____ Group#: _____ Group Name: _____

2ndary Ins? □ Yes _____ ID#:_____ GR#_____
□ No Verification Phone: _____

Patient Signature: (all information on this form is correct): _____ Date:_____