CONSULTATION PHYSICAL THERAPY
of TEXAS
RETURNING YOU TO THE GAME OF LIFE

Patient Information

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

PATIENT INFORMATION

Patient Name_____
Address _____
City/State/Zip _____
Cell Phone_____
Home Phone_____
Email_____
Social Security #_____
Date of Birth _____

Employer_____
Address_____
City/State/Zip_____
Phone_____
Emergency Contact_____
Phone _____
Sex ☐ Male ☐ Female

Date of Injury_____

Referring Physician_____

RESPONSIBLE PARTY (please complete if different from patient)

Name_____
Address _____
City/State/Zip _____
Phone_____
Social Security #_____

Employer_____
Address_____
City/State/Zip_____
Phone_____

INSURANCE INFORMATION *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.*

Primary Insurance_____
Group # _____
Policy # _____
Relationship to Patient_____
Social Security # _____
Insurance Phone # _____
Medicare # _____
Medicaid # _____
Date of Birth _____

Secondary Insurance_____
Group # _____
Policy # _____
Relationship to Patient_____
Social Security # _____
Insurance Phone # _____
Sex ☐ Male ☐ Female

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**_____

427 West 20th Street, Suite 207, Houston, Texas 77008 Office: 713-961-7852 Fax: 713-961-0812