Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION					
Patient's last name:	First:	MI:	Date:	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Birth date: / /	Primary Care Physician:			Age:	Sex: ❑ M ❑ F
Street address:		City:		State & Zip:	
Cell Phone #	Home phone#		Work #	Social Security #	
Email Address:					
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION				
(Please give your insurance card or Cards to the receptionist.)				
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )
Subscriber's name:	Subscriber's S.S.:	Birth date: / /	Group no.:	Policy no.:
Name of secondary insurance (if applicable):			Subscriber's name:	
Group no.:			Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone #. Or Other ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Total Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Total Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature _Date_