Print Form

Montgomery County Rehabilitation & Sports Therapy, P.C.

Name_____Date_____

Address_____

City_____State_____Zip_____

Phone (home)_____(work)_____(cell)_____

Date of Birth_____SSN#_____

Brief Description of Problem_____

Date of Onset_____ Referring Physician_____

Primary Care Physician_____ Phone _____

Would you like to be on our email list to receive a monthly newsletter? Y N Email _____

Insurance Information

Name of Company_____ Group#_____

ID# _____Secondary Insurance Info._____

If you would like additional reports sent to doctors (other than the referring physician), lawyers, etc.

_____
_____
_____

Have you Physical therapy in the past? If so where?_____

Name and phone number of person to notify in case of emergency.

If your injury was due to a Motor Vehicle Accident or a Workers Compensation Case, please provide us with the following information, as well as back-up insurance.

Name of insurance company _____

Address_____

Phone# _____ Claim# _____

Adjuster Name _____ Ext._____

I certify that all of the information above is correct and true. I authorize permission to release information regarding my physical therapy treatment to my doctors, lawyers, and insurance company. I authorize payment directly to Montgomery County Rehabilitation & Sports Therapy, P.C. I understand it is my responsibility that payment is made for services rendered.

Signature_____ Date_____