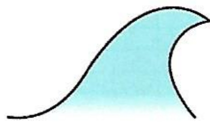


For Office Use Only:
ICD 9 ____________

## Patient Information

| Name | | Date of Birth | Sex |
|---|---|---|---|
| Home Phone | Cell/Work Phone | Email Address | |
| Home Address | | City/State/Zip | |
| Employer / School – Name & Address | | City/State/Zip | |

## Emergency Contact of Legal Guardian Information

| Name | Home Phone | Work Phone |
|---|---|---|
| Address | | City/State/Zip |

## Reason for Today's Visit

| Is this injury / condition related to your? | | | |
|---|---|---|---|
| Job Yes No | Home Yes No | Car Yes No | Other Yes No |
| Date of Injury or Accident | Please indicate the date of illness (1st symptom) | | |

## Insurance Company Information

| Insurance Name | | Insurance Phone Number |
|---|---|---|
| ID # | Group Number | Policyholder Name |
| Insurance Address | City/State/Zip | |

**I hereby give the above insurance company permission to make payment directly to the provider and physician of treatment. I further request that any and all records that are required in order to make payment to the provider / physician may be released to the above insurance company. I understand all questions asked on this form and have answered them to the best of my knowledge.**

______________________________ (Parent/Guardian to sign if patient is under 18 years of age)

______________ Date

## Medicare Patients

**I understand that La Jolla Shores Physical Therapy is not a Medicare provider. I agree not to submit claims to Medicare and agree to pay out of pocket for services rendered by La Jolla Shores Physical Therapy.**

______________________________ Signature of Patient

______________ Date