



PATIENT INFORMATION of minor child

LAST NAME _____ FIRST NAME _____ MI _____ SEX _____
ADDRESS _____ CITY/STATE/ZIP _____
HOME PHONE () _____ DOB ____/____/____ AGE _____ SS# _____ - _____ - _____

MOTHER'S INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____
MARITAL STATUS (circle one) S M D W DOB ____/____/____ SS# _____ - _____ - _____
ADDRESS (if different from patient) _____ City/State/Zip _____
Occupation _____ Employer _____ Work phone () _____ - _____
Employer's address _____ City/State/Zip _____

FATHER'S INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____
MARITAL STATUS (circle one) S M D W DOB ____/____/____ SS# _____ - _____ - _____
ADDRESS (if different from patient) _____ City/State/Zip _____
Occupation _____ Employer _____ Work phone () _____ - _____
Employer's address _____ City/State/Zip _____

REFERRED BY (NAME) _____

NEAREST RELATIVE (Not Living With You): IN CASE OF EMERGENCY

Last name _____ First name _____ Phone () _____
Address (City/St/Zip) _____ Relationship _____

INSURANCE INFORMATION

Insurance Co. Name _____ Do you have a secondary insurance carrier? YES NO
Name of Insured _____ DOB ____/____/____ SS# _____ - _____ - _____
Relationship to Patient _____ Insured's Employer _____
POLICY # _____ GROUP # _____
Primary Care Physician Name _____ Phone Number _____

***FOR RAPID PROCESSING OF YOUR CLAIMS PLEASE PROVIDE CURRENT INFORMATION.
PLEASE LET US KNOW, WHEN THERE ARE ANY CHANGES.***

I do hereby authorize medical treatment/physical therapy for my minor child and the release of any medical or other information that may be necessary for either medical care/physical therapy or in processing applications for financial benefits. I also authorize direct payment of medical/physical therapy benefits to Advanced Physical Therapy for services rendered. I understand that I am financially responsible for any

Patient Representative (parent or guardian) Signature

Date

balance not covered by my insurance.

Patient Representative (parent or guardian) Signature

Date