FUSION PHYSICAL THERAPY PATIENT INFORMATION (Please Print and Complete Fully)

Name: Last First MI	Gender	D.O.B.	Age:	SSN:	Date:

Home Address: (no PO Box)	City:	State:	Zip Code:	Marital Status:

Preferred Contact: ☐ Home ☐ Work ☐ Cell	Home Phone:	Work Phone:	Cell Phone:	Emergency Contact Phone:

Email Address:	Emergency Contact:

Patient's Employer:	Occupation:	Employer's Address or Retired from:

Spouse or Guardian:	Spouse or Guardian Phone:	Spouse/Guardian D.O.B:

Referring Physician:	Diagnosis:	Surgeon:	Date of Surgery:

Describe Nature of Injury:	Attorney:

On the Job Injury: ☐ YES ☐ NO	Date of Injury:	Auto Accident: ☐ YES ☐ NO	Date of Accident:	Attorney Phone:

INSURANCE INFORMATION

Have you signed a waiver with your medical insurance carrier excluding coverage for your diagnosis?

Primary Insurance:	Policy Number (ID Number):	Group Number:
Policy Holder:	Policy Holder Address:	
Relationship to Patient:	Policy Holder's Employer or Company Name:	Policy Holder D.O.B.:
Secondary Insurance:	Policy Number (ID Number):	Group Number:
Policy Holder:	Policy Holder Address:	
Relationship to Patient:	Policy Holder's Employer or Company Name:	Policy Holder D.O.B.:
Tertiary Insurance:	Policy Number (ID Number):	Group Number:
Policy Holder:	Policy Holder Address:	
Relationship to Patient:	Policy Holder's Employer or Company Name:	Policy Holder D.O.B.:

HIPAA

☐ I have been provided with the Notice of Privacy Practices and the Patient's Bill of Rights.

☐ Information may be released to the following persons: _____

_____

I request the following restrictions on the use and/or disclosure of my Protected Health Information:

_____

_____

_____

Signature Date

Fusion Physical Therapy accepts_____/denies_____ the requested restrictions as stated above.

_____

Signature/Title Date