

**KINETIC CHAIN PHYSICAL THERAPY
INFORMATION SHEET**

Date: _____
Referred By: _____

Attending Dr: _____
Dr's Phone #: _____

Your Name: _____	M/F	DOB: _____	Age: _____
Address: _____	City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____	
SSN: _____ - _____ - _____	Drivers License: _____	Email: _____	
Date of Injury/accident/symptoms occurred: _____		Married/Single/Widowed/Divorced	
Area to be treated: _____			

EMPLOYEMENT INFORMATION

Current Employer: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupational Title: _____ How Long Employed?: _____

PRIVATE HEALTH INSURANCE

Insurance Company Name: _____ Phone #: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Insured DOB: _____
Relationship of Insured: _____ Policy #: _____ Group#: _____

IN CASE OF EMERGENCY

Relative / Local Friend: _____ Relationship: _____
Address: _____ Phone #: _____
Patient Signature: _____ Date: _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. (spouse, relative, or friend)

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name

Patient Signature

Date