

# Powhatan Physical Therapy Corporation

1555 Standing Ridge Dr., ● Suite C-1 ● Powhatan, VA 23139

Office: 804-794-9023 ● Fax: 804-794-9373

## PATIENT INFORMATION- PLEASE PRINT CLEARLY

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Patient? Y / N

Patient's Name: \_\_\_\_\_  
First Name Last Name M.I.

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Patient SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Separated

How did you hear about us? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Employment/Student Status:  Full time employed  Part time employed  Unemployed  Retired  
 Full time student  Part time student  Other \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### EMERGENCY CONTACT

In case of an emergency, who should be notified? \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### HEALTH INSURANCE COVERAGE-*to be completed by all patients*

(In the case of workers compensation, this information will only be used if your compensation is denied)

#### PRIMARY INSURANCE

Insurance Co. Name \_\_\_\_\_ ID or Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Home Phone: \_\_\_\_\_ Policy Holder Work Phone \_\_\_\_\_

Policy Holder Cell \_\_\_\_\_

Back ⇨

**SECONDARY INSURANCE**

Insurance Co. Name \_\_\_\_\_ ID or Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder SS # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Holder Home Phone: \_\_\_\_\_ Policy Holder Work Phone \_\_\_\_\_

Policy Holder Cell \_\_\_\_\_

**WORKER'S COMPENSATION** *—Please complete this section if your injury is work related*

Insurance Company Name \_\_\_\_\_ Date of Injury \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Person \_\_\_\_\_ Claim # \_\_\_\_\_

Insurance Phone \_\_\_\_\_ Insurance Fax \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Is the injury due to an auto accident? Y / N

Date of Injury: \_\_\_\_\_

Patient Medical History: (PLEASE CHECK ALL THAT APPLY TO YOU)

Diabetic

Heart Disease

Lung Disease

Asthma

Cancer

Arthritis

High Blood Pressure

Seizures

Stroke

Hearing Loss

Other \_\_\_\_\_

Please list surgeries:

List medications:

1. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

10. \_\_\_\_\_

List allergies:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Please give date of next doctors visit: \_\_\_\_\_

Back ⇨

