# Andersonville Physical Therapy

## PATIENT INFORMATION FORM

**FULL NAME:** _____ **NICKNAME:** _____

**STREET ADDRESS:** _____ **APT #:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**DATE OF BIRTH:** _____ **GENDER:** _____

**EMPLOYER/COMPANY NAME:** _____

***If patient is under 18, please complete the following:***

**PARENT/GUARDIAN NAME:** _____

**RELATIONSHIP TO PATIENT:** _____ **DATE OF BIRTH:** _____

**EMAIL ADDRESS:** _____

*(for appointment reminders, newsletters, etc.)*

**PHONE**: (HOME) _____ (WORK) _____ (CELL) _____

***How would you prefer to receive your appointment reminders?*** HOME PHONE CELL PHONE EMAIL

- *Please note: text messages are not an option for reminders.*
- *For phone call reminders, an office manager will call the day before every appointment.*
- ***Appointment reminders are a courtesy. Please make sure that you are aware of all of your upcoming appointments.***

**REFERRING PHYSICIAN:** _____ **LOCATION:** _____

***Have you verified your physical therapy benefits with your insurance?*** yes no

**—If no, we strongly encourage you to do so, in order to help you understand your benefits and physical therapy coverage.**

***How did you hear about Andersonville Physical Therapy?***

___ Suggested by referring physician

___ Referred by a former patient (please list their name so we can thank them!): _____

___ Found APT online (please specify): ___ Google ___ Yelp ___ Facebook ___ Other: _____

___ Insurance company

___ Walk-by

___ I'm a former patient

___ Other (please specify): _____