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: _____

PHONE: (HOME) _____ (CELL) _____

- *You will receive an appointment reminder via text message prior to each 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): _____