PHYSICAL HEALTHWELL THERAPY
1200 Gough Street at Geary Blvd, San Francisco, CA 94109 Tel: 415.921.1211 info@healthwellpt.com

Patient Information New

Today's Date: _____ Date of Current Injury/Surgery: _____

Name: (First) _____ (Last) _____ (M.I.) _____

Home Address: _____

City: _____ ST: _____ Zip: _____

Best Phone#: ( ) _____ 2nd Phone#: ( ) _____ 3rd Phone#: ( ) _____
cell/home/work cell/home/work cell/home/work

Social Security#: _____ DOB: _____ Age: _____ Gender: ☐M ☐F

Email Address: _____
(Your email will be added to our database, but it will not be shared or sold)

Status: ☐Married ☐ Single ☐Divorced ☐ Domestic Partner ☐Separated ☐Widowed

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Specialty: _____ Phone: ( ) _____

Primary Care Physician: _____ Phone: ( ) _____

Who may we thank for your referral other than your doctor? _____

Occupation: _____ Employment Status: ☐ Full-time ☐ Part-time ☐ Not working ☐ Student

Injury type? ☐ Recreation ☐ Home ☐ Work ☐ Auto Accident ☐ Unknown ☐ Other: _____

Insurance - please circle all that apply: Personal Pay Health Insurance Auto Personal Injury Medicare

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MEDICARE INFORMATION - please provide card

Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No # of visits _____

Have you had speech therapy this year? ☐Yes ☐ No Do you currently have Medicare home services? ☐Yes ☐No

Medicare ID: _____ Subscriber's name if different: _____

Other Insurance: _____ Subscriber's name if different: _____

COMMERCIAL INSURANCE INFORMATION - please provide card

Insurance Company: _____ Phone: ( ) _____

Suscriber Name: _____ Relationship to patient: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Subscriber's Employer Address: _____ Phone: ( ) _____

Insurance ID Number: _____ Group Number: _____

By signing below, I agree that all of the above information is correct, and that I authorize Healthwell Physical Therapy Group to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment. I understand that I am financially responsible for payment of all charges that are not covered by (or paid for by) my insurance carrier. I understand I will be charged in full for any cancellations made less than 24 hours prior to my appointment. I understand that any patient balance exceeding 60 days will be billed to my credit card. Should my account be referred to collections, I will be responsible to pay the cost of collection, including legal fees.

Patient Signature (Parent/Guardian if necessary): _____ Date: _____