Axis Physical Therapy, Inc
505 E. Romie Lane Suite I
Salinas, CA 93901 (831) 757-3055
Student/Minor Patient Information Form

Patient Name_____ **SS#**_____
(First) (Initial) (Last)
Address_____
Street City Zip Code
Home Phone_____ **Cell Phone**_____**Work Phone**_____

Marital Status S M D W **Sex** M F **Date of Birth**_____

PARENT'S INFORMATION:

Mother's Name: _____ DOB: _____

Employer & City _____**Occupation**_____

SS#: _____**Work #**_____ **Cell#: _____**

Father's Name_____ **DOB:**_____

Employer & City_____**Occupation** _____

SS#:_____**Work #**_____**Cell#** _____

Emergency Contact _____ **Phone** _____

Family Physician_____ **Referring Physician**_____

Type of Insurance: Medicare Private Health Insurance Auto Insurance Work Comp

Injuries due to Work Yes No **Auto Accident** Yes No

Date of Injury:_____ **Time of Injury**:_____am/pm

Primary Insurance_____ **Secondary Insurance**_____

DO YOU AUTHORIZE OUR STAFF TO SPEAK TO ONE OF YOUR PARENTS?

(**CIRCLE ONE**) Yes No (**PLEASE INITIAL**) _____

By signing below, I understand and agree to the following:

I am ultimately responsible for payment of all charges incurred in this office.
I authorize Axis Physical Therapy, Inc to furnish information to my insurance carrier concerning my treatment.
I assign and request payment to Axis Physical Therapy, Inc. for physical therapy treatments.
Should the need arise to cancel my appointment, 24 hour notice is required to avoid charges which will be based on the amount time reserved for me.

I certify this information to be true and correct to the best of my knowledge.

_____ _____
Signature Date