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

Patient Name: _____ SS#:_____
(Last) (First) (Initial)

Address: _____
Street City Zip Code

Sex: M/ F Age: _____ Date of Birth: _____ Marital Status: S/M/D/W

Cell Phone:_____ Home Phone: _____Work Phone:_____

Email Address: _____

Occupation: _____

Person Responsible for Acct: SELF SPOUSE OTHER_____

Spouse Name: _____ Date of Birth:_____ Phone#:_____

EMERGENCY CONTACT NAME/PHONE: _____

Family Physician: _____ Referring Physician: _____

Whom may we thank for referring you: _____

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

Primary Insurance:_____ Secondary Insurance:_____

Date/Time of Injury: _____ Currently Employed: YES/NO

Claim #:_____ Adjuster:_____ Phone:_____

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 of time reserved for me.

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

_____ _____
Signature Date