

**CASCADE SUMMIT PHYSICAL THERAPY
PATIENT INFORMATION FORM**

PLEASE PRINT AND COMPLETE ALL ENTRIES						
Name Last	First	Middle	Date of Birth	Age	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Today's Date
Address	Street	City	State	Zip		
Home Phone ()	Message Phone ()		Social Security #			
Diagnosis			Whom may we thank for referring you to us?			
Name of Employer		Occupation	Work Phone		Extension	
Employer's Address (Street – City – State – Zip)						
Spouse's Name		Name of Employer		Work Phone		
In case of Emergency contact		Telephone #	Relationship			
Who is financially responsible for this bill?		Referring Physician		Primary Physician		
INSURANCE INFORMATION						
Primary Insurance		Address (Street – City – State – Zip)			Phone No.	
Name of Insured		Relationship	Insured DOB	I.D. No.	Group No.	
Date of Injury			Claim No.			
Secondary Insurance		Address (Street – City – State – Zip)			Phone No.	
Name of Insured		Relationship	I.D. No.	Claim No.	Group No.	
Date of Injury						
Attorney		Address (Street – City – State – Zip)			Phone No.	

I authorize you to disclose to the above described insurance companies any medical or other information necessary to obtain payment for the services you provide me. This authorization shall apply to all future services provided to me and shall not expire. I assign Cascade Summit Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature

Date