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PACE WEST physical therapy

PATIENT INFORMATION FORM

Today's Date:_____ **Date of Birth** _____

Full Legal Name _____ **Gender** M____ F____ Other _____
First Middle Last

Permanent Mailing/Billing Address
_____ City _____State_____ Zip _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email Address _____

Emergency Contact _____ parent___spouse___friend___ Other: _____

Emergency Contact Phone _____

Name of Referring Doctor_____ **Date Last Seen** _____

Employer _____ **Occupation** _____

How did you hear about our TNE program? Internet ___ Email ___ Friend ___ Spouse ___

Who can we thank for referring you to us? _____

- I authorize the release of any medical information necessary to process the claims for services rendered. I further authorize payment of medical benefits directly to Pace West Physical Therapy. _____
  initial
- We stringently maintain the privacy of patient health information. A Notice of Privacy Policies is posted in the waiting room. If you wish to review our privacy practices, please ask the front desk receptionist to provide you with a copy of our policy.
- I hereby acknowledge that I consent to treatment at Pace West Physical Therapy. _____
  initial
- **I verify that the above information is to the best of my knowledge accurate and complete.**

_____ _____
Patient or authorized person Signature Date