GLINN & GIORDANO PHYSICAL THERAPY

☐ Downtown
☐ Northwest
☐ Southwest
☐ North
☐ Shafter

Patient Information ☐
Insurance Information ☐
Insured's DOB ☐
Injury / Condition ☐
Medical History ☐

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ Zip: _____
Work Phone: _____ Home Phone: _____ Cell Phone: _____
SS#: _____DOB: _____ Sex: Choose One Martial Status: ☐ Single ☐ Married ☐ Other
Age: _____ Height: _____ Weight: _____ E-mail: _____
Occupation: _____ Currently Working: Choose One Employer: _____
Work Restrictions per MD: Choose One Attorney: Choose One Attorney Name: _____
Person to contact in case of emergency:
Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION (PLEASE COMPLETE ALL INSURANCE INFORMATION)

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Subscriber Number: _____
Group Number: _____ Subscriber Name: _____ Relationship: _____
Subscriber DOB: _____ Subscriber SSN: _____-_____-_____ Insured Employer: _____

SECONDARDY INSURANCE INFORMATION

Name of Insurance: _____ Subscriber Number: _____
Group Number: _____ Subcriber Name: _____ Relationship: _____
Subscriber DOB: _____ Subscriber SSN: _____-_____-_____ Insured Employer: _____

INJURY / CONDITION INFORMATION

What problem or diagnosis brings you in today? _____
_____
Date of Injury: _____ Type of Injury/Condition: ☐ Auto Accident ☐ Work Injury ☐ Accident ☐ Sports ☐ Unknown
Did you have surgery? Choose One Date of Surgery: _____ Type of Surgery: _____
Referring Physician: _____ Date of Physical Therapy Order: _____
Have you had prior care this year? ☐ Physical Therapy ☐ Chiropractic ☐ Occupational Therapy # of times: _____
Please explain how your condition happened? _____
_____

FOR OFFICE USE ONLY

Patient Number: _____ Account Type: _____ Date: _____ Diagnosis: _____