

Patient Information

Name _____ Primary Phone _____
Address 1 _____ Secondary Phone _____
Address 2 _____ Email _____
City _____ Birth Date _____
State _____ Gender _____
Zip Code _____

Would you like to receive appointment reminders? Email No Reminders

Emergency Contact _____ Number _____ Relation _____

Case Information

Area to be treated 1 _____ Involved Side _____
Area to be treated 2 _____ Involved Side _____
Preferred PT _____ Dominant Side _____
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____
How did you hear about Apex Physical Therapy? _____

Primary Insurance Information

Insurance Name _____ Insured's Phone _____
Insurance ID _____ Insured's Birth Date _____
Policy Number _____ Insured's Gender _____
Insured's Name _____ Insured's Employer _____
Insured's Address _____ Relationship to Insured _____

Secondary Insurance Information

Insurance Name _____ Insured's Phone _____
Insurance ID _____ Insured's Birth Date _____
Policy Number _____ Insured's Gender _____
Insured's Name _____ Insured's Employer _____
Insured's Address _____ Relationship to Insured _____