PEAK
Physical Therapy

Full Name: _____ **Date of Birth:** _____
First Last MI

Gender: Male Female **SS #:** _____-_____-_____ (needed Medicare , MVA & WC)

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

E-Mail: _____

Mailing Address: _____
Street Apt City State Zip

Emergency Contact: _____ **Phone:** (____) _____-_____ **Relationship:** _____

Referring Physician Name: _____ **Primary Care Physician:** _____

Is this the PCP on file with your Health Insurance Carrier? ☐ Yes ☐ No (If no, please update ASAP with insurance)

Diagnosis/Body part: _____ **Date of Injury/Pain**_____

Have you had any other physical therapy treatment this year? ☐ Yes ☐ No

Is this related to a recent surgery? ☐ Yes, date of surgery: _____ ☐ No

How did you hear about Peak Physical Therapy? _____

Primary Insurance Name: _____

Subscriber ID #: _____ **Group/Policy #:** _____

Are you the subscriber? ☐ Yes ☐ No (if answered no, please fill out subscriber information below)

Subscriber Name: _____

Subscriber DOB: _____ Relationship: _____

Secondary Insurance Name: _____

Subscriber ID #: _____ **Group/Policy #:** _____

Are you the subscriber? ☐ Yes ☐ No (if answered no, please fill out subscriber information below)

Subscriber Name: _____

Subscriber DOB: _____ Relationship: _____

Was this injury caused by an accident? ☐ Yes ☐ No

If yes, what type of accident? ☐ Work ☐ Auto ☐ Other: _____

Date of Injury: _____ **State Accident Occurred In:** _____

Report filed with: ☐ Auto Insurance ☐ Employer ☐ Other: _____ ☐ None

Do you have any attorney assigned to your case? ☐ Yes ☐ No ☐ Pending ☐ Unsure

Attorney: _____ Law firm: _____ Phone #: (____) ____-_____

Has an **Auto Insurance** claim been opened for medical bills? ☐ Yes ☐ No ☐ Not pursuing claim

Policy type: ☐ Own Policy ☐ Other Party Policy Claim #: _____

Insurance Name: _____ Adjuster Name: _____

Phone number: (_____) _____-_____ Fax #: (_____) _____-_____

Worker's Compensation: Has your claim been accepted? ☐ Yes ☐ No

Claim #: _____ Insurance Name: _____

Employer Name: _____ Phone #: (____) ____-_____ Fax #: (____) ____-_____

Address: _____

Street City State ZIP

Adjuster Name: _____ Phone #: (____) ____-_____ Fax #: (____) _____-_____

Treatment Consent: I give my consent for Peak Physical Therapy, LLC to provide me with necessary medical care and treatment for diagnosing and treating my condition. I understand that I am requesting these services at my discretion. I am responsible for communicating all important information to my therapist and office staff, as may be required for the individual needs of my treatment plan and billing process.

Patient/Guardian Signature: _____ Date: _____

Please bring photo ID and Insurance Card for verification with you to your first appointment and be sure to let us know if your insurance, name, or any other medical or personal information we have on file is out of date. Thank you so much, and we look forward to seeing you for your first appointment!