

KITSAP PHYSICAL THERAPY & SPORTS CLINICS

How did you hear about us? Dr. Friend/Relative Fitness Center Newspaper Lecture Series Other _____

Have you ever had Physical Therapy before? Yes No If yes when ____/____/____

Male / Female (circle one) Today's Date _____

Minor YES / NO Parent or Guardian _____

Patient Name _____ Birthdate _____
Last First MI

Mailing Address: _____ / _____
(E-mail optional)

City: _____ Zip: _____ Home Phone: () _____

Referring Dr: _____ PCP _____ Patients SSN: _____
(required to bill L & I)

Employer: _____ Work Phone: _____

Emergency Contact _____ PH # _____

Date of Onset or reoccurrence of injury: _____ (mm/dd/yyyy)
All insurance companies require Month-Date-Year in order for us to bill

Cause (i.e. fell skiing, yard work, sports, etc.): _____

Body Part affected (be specific i.e. right knee, left elbow, etc.) _____

Was this a JOB related injury? YES / NO (If yes complete information below)

Claim # _____ (USA) State in which injury occurred _____

Was this an Auto accident? YES / NO (If yes complete information below)

Is there an at fault party or 3rd payer involved? YES / NO

Date of Accident ____/____/____ Location of Accident _____
ADDRESS

At Fault Party: _____
NAME ADDRESS ZIP

Patient's (PIP) Ins. _____ Ph # _____ Adjuster _____ Claim # _____
Address _____ City _____ Zip _____

At fault party Ins. _____ Ph # _____ Adjuster _____ Claim # _____
Address _____ City _____ Zip _____

Do you have an attorney? YES / NO

Attorney: Name _____ PH # _____

Address _____ City/State _____ Zipcode _____

Verified by: _____

OFFICE USE

Int. tr. _____

PT _____