RIVER PARISH
Physical Therapy & Wellness

PATIENT INFORMATION

Date: _____ Referring Doctor: _____

PLEASE PRINT CLEARLY Home Phone: _____

First Name: _____ Cell Phone: _____

Last Name: _____ Birth Date: _____

Address: _____
City, St., Zip: _____

Male: _____ Female: _____ Age: _____
Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

City, St., Zip: _____ Driver's License #: _____

Date last worked: _____ Has your employment terminated? _____

Name of spouse or legal guardian: _____

Employer: _____ Birth Date: _____

Address: _____ Work Phone: _____

City, St., Zip: _____

May we leave voicemail/text messages or Email regarding your appointments at the following?
Home: Yes _____ No _____ Work: Yes _____ No _____ Cell: Yes _____ No _____

Email address: _____

How did you learn of our practice?
Doctor: _____ Family/Friend: _____ Insurance: _____ Internet: _____ Other: _____

Emergency Contact: _____ Ph # _____

Type of Payment? Insurance Co. _____ Cash _____ Workers Comp _____

Insurance Policy # _____ Subscriber / DOB: _____

Is condition due to one of the following:
Work Related: _____ Auto Accident: _____ Other; Please Describe: _____