Quality Therapy Services, Inc.
Patient Information Sheet

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Cell Phone: _____

Birthdate: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated ☐ Other

Email Address: _____ Referring Physician: _____

Employer: _____ Work Phone: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Relationship: _____ Phone: _____

How many physical therapy visits have you received this year at Quality Therapy or any other Therapy Office? _____

Are you currently receiving home health services? ☐ Yes ☐ No

How did you hear about Quality Therapy Services, Inc? (Please Check One Below)

☐ Doctor's Office ☐ Friend / Family Member ☐ Newspaper ☐ Phone Book ☐ Other

***** PLEASE BRING PHOTO ID, INSURANCE CARD, AND THERAPIST PRESCRIPTION TO 1ST APPOINTMENT*****

PRIMARY INSURANCE INFORMATION

Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder Relationship: ☐ Self ☐ Spouse ☐ Other _____ IF NOT "SELF"

POLICY HOLDER NAME: _____ SS # _____ DOB: _____

SECONDARY INSURANCE INFORMATION

Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder Relationship: ☐ Self ☐ Spouse ☐ Other _____ IF NOT "SELF"

POLICY HOLDER NAME: _____ SS # _____ DOB: _____