Integrated Physical Therapy of Colorado, P.C.

PATIENT INFORMATION

First Name**:**_____Last Name:_____ MI: _____

Date of Birth:_____/_____/_____ SSN:_____ Sex: Male / Female

Address:_____

City/State:_____ Zip:_____

Phone: (____)- _____Mobile: (____)-_____Work**:** (____)-_____

Email Address:_____

What is the best number to reach you at? (Please circle) Home Mobile Work

How would you like to receive appointment reminders? Home Mobile Work Text Email

Would you like to receive our e-newsletter? Yes No

Referred by
Name:_____Address:_____Phone:_____

Primary Care Doctor
Name:_____Address:_____Phone:_____

Emergency Contact
Name:_____ Phone:_____ Relationship to patient:_____

Have you received Physical Therapy this year? Yes No

If yes, where, and how many visits? _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder Name:_____ Relationship to Policy Holder:_____

Employer of Policy Holder:_____ Member ID:_____

Secondary Insurance: _____

Policy Holder Name: _____ Relationship to Policy Holder:_____

Member ID:_____ Group Number:_____

CONDITION INFORMATION

Is your condition due to an accident?_____ Date of Accident:___/_____/_____

Please provide any additional
information:_____