



STEAMBOAT PHYSICAL THERAPY

Percival Creek Professional Plaza | 2102 Carriage Drive SW, Suite B, Olympia, WA 98502

Office 360.866.0408 | Fax 360.866.1165 | Clinic hours: Monday - Friday, 7:00 a.m. to 5:30 p.m.

PATIENT REGISTRATION: Please bring to first appointment. Date: _____

Patient name: _____ M F Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital status: S M D W Phone: _____ Cell #: _____ S.S. #: _____

Referring physician: _____ Primary physician: _____

Employer: _____ Occupation: _____ Phone: _____

Date of symptoms/injury: _____ Date of surgery: _____ Job related? Y N Auto accident? Y N

If yes, is an attorney involved? Y N Name and phone #: _____

Spouse's name: _____ Spouse's employer: _____ Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Where did you hear about our clinic: _____

INSURANCE INFORMATION

Primary insurance: _____ Secondary Insurance: _____

Name of insured: _____ DOB: _____ Name of insured: _____ DOB: _____

ID #: _____ ID #: _____

Employer: _____ Employer: _____

Ins. Phone: _____ Group/Policy #: _____ Ins. Phone: _____ Group/Policy #: _____

Patient's relationship to insured: _____ Patient's relationship to insured: _____

Medicare patients: Have you received home health care in the past 60 days for physical therapy? Y N

PRIOR THERAPY TREATMENT THIS YEAR

Number of visits: Massage: _____ Physical Therapy: _____ Speech: _____ Occupational: _____

WORKER'S COMPENSATION INSURANCE INFORMATION

Employer: _____ Contact Person: _____ Phone: _____

W/C Carrier: _____ Claim Manager: _____ Phone: _____

Claim #: _____ DOI: _____

Number of visits: Massage: _____ Physical Therapy: _____ Speech: _____ Occupational: _____

MOTOR VEHICLE ACCIDENT / LIABILITY INSURANCE INFORMATION

Auto policy holder's name: _____ Auto insurance carrier: _____

Date of accident: _____ Claim #: _____

Adjuster: _____ Phone: _____

FOR OFFICE USE ONLY

Benefits verified: Y N Verified by: _____ Date: _____ Initial: _____ Deductible: _____

Met: _____ % Payable: _____ % Max # of visits/limits: _____ Effective date: _____

In network: _____ Out of network: _____

Additional comments: _____

Mail billing to: _____

Appointment date/time: _____ Therapist: _____ Info taken by: _____