# LANE PHYSICAL THERAPY CENTER, inc.

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| (Please Print) |
| PATIENT INFORMATION |
| Patient’s Last Name (Legal Name): | First: | Middle: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital Status (circle one) |
|  | Single / Mar / Div / Sep / Wid |
| Preferred Name | Suffix: Sr., Jr., etc. |  | Birth Date: | Age: | Sex: |
|  |  |  |  / / |  | ❑ M | ❑ F |
| Mailing Address: | Social Security No.: | Home Phone No.: |
|  |  | ( ) |
| City: | State: | Zip Code: |  |
|  |  |  |  |
| Home Phone No.: | Cell Phone No.: | Employer Phone No.: | Ext. : |
| ( ) |  ( )  | ( ) |  |
| Email:  | Primary Language: | Race: | Are you Pregnant:  |
|  |  |  | ❑ Yes ❑ No |
| Occupation: | Employer:  |
|  |  |
|  |
| responsible party INFORMATION |
| (Please give your insurance card to the receptionist.) |
| Responsible Party’s Last Name:  | First: | Middle : | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Marital Status (circle one) |
|  | Single / Mar / Div / Sep / Wid |
| Suffix: Sr., Jr., etc. | Mailing Address:  | City:  | State | Zip Code |
|  |  |  |  |  |
| Email: | Home Phone No. : | Work Phone No.: | Ext.:  | Cell Phone No.: |
|  | ( )  | ( )  |  | ( )  |
| Sex:  | Birth Date: | Social Security No.: | Patient’s Relationship to Responsible Party : |
| ❑ M | ❑ F |  / / |  | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|  |
| INSURANCE INFORMATION |
| Patient’s Relationship to Subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |  |
| Subscriber’s Name: (As Listed on Card) | Subscriber’s Birth Date: | Insurance Company Name:  |
|  |  / / |  |
| Are you Claiming Worker’s Comp? ❑ Yes ❑ No |   |  |
|  |  |
| IN CASE OF EMERGENCY |
| Name of Local Friend or Relative: | Home phone No.: | Cell Phone No.: | Work Phone No.: |
|  | ( ) | ( ) | ( ) |
| Relationship to Patient: |
| **The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LANE PHYSICAL THERAPY CENTER or insurance company to release any information required to process my claims.** |
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|  | **Patient/Guardian Signature** |  | **Date** |  |