# 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.: | | | | | | | | | | | |
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| City: | | | | | | | | | | | | | | | | State: | | | | | | | | | | | Zip Code: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
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| Home Phone No.: | | | | | | | Cell Phone No.: | | | | | | | | | | | | | | | | | | | | | | | | | | Employer Phone No.: | | | | | | | | | | | | | | | | | | | Ext. : | | | | | |
| ( ) | | | | | | | ( ) | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | | | | | | | |  | | | | | |
| Email: | | | | | | | | | | Primary Language: | | | | | | | | | | | | | | | | | | Race: | | | | | | | | | | | | | | | | | | | Are you Pregnant: | | | | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | ❑ Yes ❑ No | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Are you Claiming Worker’s Comp? ❑ Yes ❑ No | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Local Friend or Relative: | | | | | | | | | | | | | | | | | | | | Home phone No.: | | | | | | | | | | | | | | | | | Cell Phone No.: | | | | | | | | | | | | | | Work Phone No.: | | | | | | |
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| 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.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |  |
|  | **Patient/Guardian Signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | **Date** | | | | | | | | | | | | | | | |  |