

# *SUNSET PHYSICAL THERAPY*

## **Patient Information Form**

NAME: \_\_\_\_\_ GENDER \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE#: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

SSN: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE#: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

EMERGENCY PHONE #: \_\_\_\_\_

PERSON WHO REFERRED YOU: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

INSURED'S SSN: \_\_\_\_\_ RELATION: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

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**ASSIGNMENT OF BENEFITS:** I hereby assign all medical benefits to Sunset Physical Therapy. I understand that I am financially responsible for any co-payments, deductibles, and non-covered expenses.

**ASSIGNMENT TO RELEASE INFORMATION:** I hereby authorize the release of any information pertinent to my case to any insurance company, adjuster, or health care professional involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

\_\_\_\_\_  
INSURED'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE