OMAHA PHYSICAL THERAPY INSTITUTE, P.C.

Patient Information

Patient Name_____( )MALE ( )FEMALE

Address_____

City_____State_____Zip Code_____Home Phone_____

Cell Phone_____ Email Address_____

Date of Birth_____Date of Injury/Onset_____Diagnosis_____

Parent Name (If minor)_____

Parent Employer (If minor)_____

Referring Physician/ Clinic location_____

Family Doctor_____

Related to Auto Accident: **YES/NO** Related to your employment: **YES/NO** Sports Injury: **YES/NO**

Employer Name_____

PRIMARY INSURANCE_____

Subscriber Name_____Date of Birth_____

Claim #_____Group #_____

Subscriber Employer_____

SECONDARY INSURANCE_____

Subscriber Name_____Date of Birth_____

Claim #_____Group #_____

Subscriber Employer_____

IN CASE OF ACCIDENT OR EMERGENCY, WHOM SHOULD WE CONTACT?

Name_____Relationship_____

Address_____

City/State_____Zip Code_____

Daytime Phone_____Cell Phone_____

I understand that I am financially responsible to Omaha Physical Therapy Institute, PC for all expenses incurred, and that my insurance carrier may apply amounts to deductible, co-pays, and/or coinsurance, for which I will be billed and must pay to Omaha Physical Therapy Institute, PC. If there is a question regarding the payment or denial of claims, I understand that I must contact my insurance representative for clarification. I further understand that payment is due 30 days after receiving the billing statement. If there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

_____ _____

Signature Date