

# Hoquiam Therapy Services

## Patient Information Form

---

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Physical Address \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Work( ) \_\_\_\_\_ Cell( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

### **Emergency Contact**

---

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone( ) \_\_\_\_\_

### **Employer**

---

Name \_\_\_\_\_ Phone( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### **Problem**

---

Problem Description \_\_\_\_\_ Date of Injury/Illness \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Work Related Injury? Yes\_\_\_ No\_\_\_ Motor Vehicle Accident? Yes\_\_\_ No\_\_\_ State \_\_\_\_\_

### **Insurance**

Insurance \_\_\_\_\_

ID \_\_\_\_\_ Group \_\_\_\_\_

Subscriber (if other than self)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

### **Insurance**

Insurance \_\_\_\_\_

ID \_\_\_\_\_ Group \_\_\_\_\_

Subscriber (if other than self)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

I give my consent and authorization to Hoquiam Therapy Services to treat my condition. I understand I am financially responsible for all charges, whether or not paid by my insurance. I authorize the release of all information necessary to secure the payment of insurance benefits.

**Signature of Patient/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_