

Ocean Shores 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** _____