PATIENT INFORMATION

(Please print eligibly)

Name:____

Mailing Address:______________________________________

City:____________________**Zip:**_______________________

Date of Birth:_________ **Male** ☐ **Female** ☐ **Prefer not to say** ☐

Home Phone:________________**Cell Phone:**________________

Email Address:____

Ok to email for appointment reminders? **Yes** ☐ **No** ☐

Referring Physician:____________________________________

Who may we thank for your referral?______________________

Emergency Contact:_____________________________________

Phone:______________________ **Relation:**_________________

Employer:____

Insurance Information:

Private ☐ **Worker's Comp.** ☐ **Auto Accident** ☐ **Self Pay** ☐

If worker's comp. or auto accident claim, please bring claim number & contact information associated with claim

Primary Insurance:______________________________________

Secondary Insurance:____________________________________

Please bring in copy or physical insurance card/s with member ID, Group number & insurance contact information

PLEASE READ

We strongly suggest that you familiarize yourself with your insurance coverage as it pertains to your physical therapy benefits. Lyons Physical Therapy sends patient statements at the first of the month following the processing of claims by your insurance company. Please let us know if you wish to pay your co-payment or deductible payment more frequently.