TIM FOLEY PHYSICAL THERAPY

Patient Information Sheet

Date _____

Referring Physician/
Referral Source: _____

PATIENT INFORMATION

Patient Name _____ Age _____ Birth Date ____/____/____ Sex _____
Last First Middle Initial

SS# ____/____/____ e-mail: _____ Home Ph: _____

Mailing Address _____ Cell Ph: _____
Street City State Zip

Employer _____ Work Phone (____) _____
Name Address (Street, City, State, Zip)

Spouse, Friend Or Relative _____ Phone (____) _____
Name Address (Street, City, State, Zip)

Patient's condition related to: ☐ Employment ☐ Auto ☐ Other_____ Date of Injury ____/____/____

Name and address of employer at time of injury _____

INSURED/RESPONSIBLE PERSON'S INFORMATION
(If patient is the insured/responsible party you may skip this section)

Name _____ SS# ____/____/____
Last First Middle Initial

Relationship to Patient: ☐ Spouse ☐ Child ☐ Other _____ Birth Date _____

Address _____ Phone (____) _____
Street City State Zip

Employer _____ Phone (____) _____
Name Address (Street, City, State, Zip)

INSURANCE

☐Auto ☐ Workman's Comp ☐ Group/Personal ☐ Medicare ☐ Other _____

Primary Insurance Co. _____ ID # _____ Group # _____

Address _____ Phone (____) _____
Street City State Zip

Policy Holder's Name & Address _____

Secondary Insurance Co. _____ ID # _____ Group # _____

Address _____ Phone (____) _____
Street City State Zip

Policy Holder's Name & Address _____
Birth date: _____

Tim Foley Physical Therapy
1700 12th Street, Suite C
Hood River, OR 97031
(541) 386-9735
Fax (541) 386-2015