7941 New Chipping Lane, New Kent, VA 23124
Phone: 757-969-5200 Fax: 757-969-5201

PERSONAL INFORMATION:

Patient Name: ___________________________ DOB: ______________

Social Security Number: ___________________________ Male ☐ Female ☐

Address: ___________________________ City, State, Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

E-mail: ____

Would you like appointment reminders via? E-mail ☐ Text Message ☐

Marital Status: ____________________ Spouse Name & DOB: ____________________

Employer: ___________________________ Employer's Phone: ______________

Employer's Address: ____

Emergency Contact: ___________________________ Relationship: ______________

Emergency Contact Phone: ____

If patient is under 18; Mother's Name & SS #: ___________________________

Father's Name & SS #: ____

INSURANCE INFORMATION: (Please present insurance cards and ID)

Primary Insurance: ____________________ ID Number: ____________________

Policy Holder / Responsible Party Name: ___________________________ DOB: ______________

Social Security Number: ____________________ Relation to Patient: ______________

Secondary Insurance: ____________________ ID Number: ____________________

Policy Holder / Responsible Party Name: ___________________________ DOB: ______________

Social Security Number: ____________________ Relation to Patient: ______________

Have you received any prior outpatient physical, occupational, or speech therapy, or any home-health services in the current calendar year?

Yes _______ No _______ If yes, please indicate which type(s): ____

Location: ____ Approx. date of last visit: ___________________

Can information regarding your care with APEX Physical Therapy be shared with any other individuals? If so, please indicate whom:

____

Who is your primary care physician? ____

Which doctor referred you to APEX? ____

How did you hear about us? ____

Please initial the following;

Consent to Treatment: I consent to rehabilitation and related services at APEX. __________

I have received a copy of APEX's Notice of Privacy Practices. _________

I have received a copy of APEX's Financial Agreement. _________

I acknowledge there will be a $25 missed appointment fee applied to any appointment that is missed or not cancelled within 24 hours of the appointment time. Cancellations must be called in to our office directly or left on our voicemail if the office is closed. _________

Printed Name: ____

Signature: ____ Date: _________________________

Relation to Patient: ____