5485 Mooretown Road, Suite E, Williamsburg, VA 23188
Phone: 757-969-5200 Fax: 757-969-5201

PERSONAL INFORMATION:

Patient Name: ____ DOB: _______________________

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; Parent/Guardian's Name & DOB: ____

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 was presented a copy of APEX's Notice of Privacy Practices. __________

Printed Name: ______________________________

Signature: ______________________________ Date: ______________

Relation to Patient: ______________________________