ECLIPSE

PHYSICAL THERAPY & SPORTS PERFORMANCE

Patient Information

Today's Date	☐ Auto ☐ Worker's Comp ☐ Other	Area to be Treated	
Last Name		First Name, Middle Initial	
Street Address	Town	State	Zip Code
Home Phone	Work Phone	Cell Phone	Email
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
Please remind me of appointments by: ☐ Email : ______________________________		Please send me your newsletter ☐ Yes ☐ No	
Emergency Contact Name:	Phone	Relationship to Patient	
Employer		Occupation	
Employer Street Address	Town	State	Zip
Primary Care Physician Name	Phone #	Have You Had Physical Therapy Before? ☐ Yes ☐ No	
Referring Physician Name	Phone #	If yes, when:	
Primary Health Insurance Carrier	Member ID#	Group #	
Primary Insured Name	Insured Date of Birth	Relationship to Patient	
Address (if different from patient)		Insured Phone #	
Secondary Health Insurance Carrier (if applicable)	Member ID#	Group #	
Primary Insured Name	Insured Date of Birth	Relationship to Patient	
Address (if different from patient)		Insured Phone #	
Worker's Comp/Auto Information (if applicable) Insured Name	Adjuster Name	Claim#	
Insurance Address and Phone #		Date of Injury	
Attorney Name, Address and Phone #			
Are you currently, or have you recently had home health services? ☐ Yes ☐ No	If yes are you still receiving service? ☐ Yes ☐ No		
	If no, when were you discharged?		
How did you hear about us?			