LARRY HAM & ASSOCIATES
PHYSICAL THERAPY

Thank you for choosing our office. In order to serve you properly, we will need the following information. ALL information will be strictly confidential.

PATIENT INFORMATION

Name (Last): _____(First): _____ (MI): _____ □ Female □ Male

Mailing Address: _____ (City): _____ (State): _____ (ZIP): _____

Date of Birth: _____ Marital Status: □ M □ S □ W □ D Spouse's Name: _____

Phone#: Home_____ Cell_____ Work_____

Do you want appointment reminders? YES ___ NO ___ If YES indicate best method: Phone ___ Text ___ Email ___

If YES, please circle BEST phone# above OR provide BEST Email: _____

Patient's Employer: _____ (Occupation): _____

Referring Doctor's Name: _____ When do you recheck with your doctor? _____

***Have you had ANY physical therapy this year? YES ____ NO____ If YES, explain: _____**

(if NOT SELF) PERSON RESPONSIBLE FOR PAYMENT

Name (Last): _____ (First): _____ (MI): _____ Relationship to Patient: _____

Mailing Address: _____ (City): _____ (State): _____ (ZIP): _____

Home/Cell #: _____ Employer: _____

Work #: _____ Are calls allowed at work? □ YES □ NO

NEAREST FRIEND/RELATIVE TO CONTACT IN CASE OF EMERGENCY

Name: _____ Contact #: _____ Relationship to Patient: _____
Do you allow the release of your confidential medical and billing information to this person? □ YES □ NO

REASON FOR YOUR VISIT

Location of painful area: _____ □ Left □ Right □ Bilateral

If injury, date occurred: _____ How did your injury occur? □ Work □ Auto □ Sports □ Other □ None

Injury/Accident details: _____

Did you have surgery: □ Yes □ No If Yes, date of surgery: _____ Surgeon: _____

INSURANCE INFORMATION

Name of Medical Insurance: _____ Phone #: _____

Subscriber Name: _____ DOB: _____ ID#: _____ Group#: _____

Name of Secondary Insurance: _____ Phone #: _____

Subscriber Name: _____ DOB: _____ ID#: _____ Group#: _____

ATTORNEY INFORMATION (if there is one involved in this case)

Attorney Name: _____ Phone#: _____