Carolina Physical Therapy and Sports Medicine, Inc.

PATIENT DATA SHEET

MR#____

PATIENT INFORMATION

First ______________________ Middle ___________________Last ______________________________

Date of Birth: ________________ Age _______ Gender [ ]Male [ ]Female [ ]Other _____________________

ADDRESSES

Mailing Address: ____

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____

Physical Address: ____

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COMMUNICATIONS

[ ]OK to Call: Home _____________________________ Best time to call ________________________

[ ]OK to Call: Work _____________________________ Best time to call ________________________

[ ]OK to Call: Cell _____________________________ Best time to call ________________________

Preferred Language: ____ Interpreter Required [ ]Yes [ ]No

RELATIONSHIP STATUS

[ ]Married [ ]Single [ ]Divorced [ ]Widowed [ ]Separated [ ]Unknown

STUDENT STATUS:

[ ]Full-time [ ]Part-time [ ]None

INJURY INFORMATION:

Date of Injury: ____ Referring Physician _____________________

Injury Area: ____

Auto or Work Accident: ____

EMPLOYMENT STATUS:

[ ]Active Military [ ]Full-Time [ ]None [ ]Part-Time [ ]Retired [ ]Self Employed

PATIENT EMPLOYER INFORMATION

Employer: ____ Occupation: ______________________________

Address: ____

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Phone: ____

SPOUSE EMPLOYER INFORMATION

Employer: ____ Occupation: ______________________________

Address: ____

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Phone: ____

Carolina Physical Therapy
PATIENT DATA SHEET

INSURANCE INFORMATION

Primary Insurance ____

Policy Holders Name: ____

Holder's Birth Date: ____

Policy or Certificate #: ____________________ Group#: ____________________

Policy Holder's Employer: ____

Secondary Insurance: ____

Policy Holder's Name: ____

Holder's Birth Date: ____

Policy or Certificate #: ____________________ Group#: ____________________

Policy Holder's Employer: ____

OTHER SERVICES

Are you receiving, or have you received Home Health Services? [ ]Yes [ ]No

Are you receiving, or have you received other therapy services? [ ]Yes [ ]No

HOW DID YOU HEAR ABOUT US?

[ ]Adjustor
[ ]Attorney
[ ]Case Manager
[ ]Cross Referral
[ ]Employer
[ ]Former Patient
[ ]Friend
[ ]Hospital
[ ]Marketing Ad - Billboard
[ ]Marketing Ad - Direct Mail - Email
[ ]Marketing Ad - Facebook
[ ]Marketing Ad – Other
[ ]Marketing Ad - Print
[ ]Marketing Ad - TV
[ ]Open Houses
[ ]Physician
[ ]School
[ ]Self
[ ]Word of Mouth
[ ]Other ____________________

EMERGENCY CONTACTS

Name	Relationship	Home	Cell	Fax

Patient Signature: ____

Date: ____________________