

ENCORE

PHYSICAL THERAPY

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Patient Information				
Today's Date:				
Last Name:	First Name:	MI:	DOB:	M () F ()
Address:				
City:		State:	Zip:	
Home Phone:	Cell Phone:	Social Security #:		
Employment Status: Employed() Disabled() Retired() Student()			Employer:	
Emergency Contact:	Phone:	Relationship:		

Referring Physician Information	
Referring Dr:	Referring Dr. Phone:
Primary Dr:	Primary Dr. Phone:
Reason for today's visit/Diagnosis:	

Insurance Information		
Primary Carrier:	ID#:	Group #:
Policy Holder (If Different):	Relationship: Self () Spouse () Child () Other ()	
Secondary Insurance:	ID#:	Group #:
Policy Holder (If Different):	Relationship: Self () Spouse () Child () Other ()	

Auto/Work Injury Claim		
Insurance Carrier:	Claim #:	Date of Injury:

Miscellaneous	
How did you hear about us? Friend/family() Dr.() Insurance() Previous Patient() Website() Other()	
Would you like to be added to our emailing list? Yes() No()	Email Address: