ENCORE
PHYSICAL THERAPY

Todays Date_____

First Name:_____**MI**_____ **Last Name:**_____

Date of birth:_____ **Male** ◯ **Female** ◯

Address:_____City:_____State:_____Zip:_____

Telephone:_____ Cell Phone:_____

Patient Email:_____

Emergency Contact Name:_____ Telephone:_____

Insurance Information

Primary Insurance:_____ID#_____Group#_____

Policy Holder:_____DOB:_____

Secondary Insurance:_____ID#_____Group#_____

Policy Holder:_____DOB:_____

Auto/Work or personal Injury Claim Information

Insurance Carrier:_____

Claim#:_____

Date of Injury:_____

Adjuster's Name:_____

Adjuster's Telephone:_____

Referring Physician's Information

Referring Provider:_____ Telephone:_____

Primary Provider:_____ Telephone:_____

To help us help you, please complete this form. Thank you!