



INTEGRATED PHYSICAL THERAPY, LLC  
Phone 1-608-658-5352  
Fax 1-480-287-9232

**Patient Information**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ sex \_\_\_\_\_ male \_\_\_\_\_ female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

e-mail address \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

**Are you currently receiving Home Health Services** \_\_\_\_\_

**Have you received Physical Therapy or Speech Therapy this year** YES \_\_\_\_\_ NO \_\_\_\_\_

**Primary Insurance Information**

Name of Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Number \_\_\_\_\_ Relation to Subscriber \_\_\_\_\_

**Second Insurance Information**

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Number \_\_\_\_\_ Relation to Subscriber \_\_\_\_\_

**Is this a workcomp claim** \_\_\_\_\_ yes \_\_\_\_\_ No Claim # \_\_\_\_\_

Contact \_\_\_\_\_ Phone \_\_\_\_\_ Date of Injury \_\_\_\_\_

**Is this a personal injury or motor vehicle claim** \_\_\_\_\_ yes \_\_\_\_\_ no

Attorney Name \_\_\_\_\_ Phone \_\_\_\_\_