CONFIDENTIAL PATIENT FORM

TPTC
1230 NORTH CONVENT, SUITE A
BOURBONNAIS, IL 60914
THE PHYSICAL THERAPY CENTER LTD.
(815) 935-8782

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Address		
City, State, Zip		
Home Phone: ( )	Cell Phone (optional): ( )	
Social Security #	Date of Birth	Gender ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Self Employed	Student Status ☐ Full Time ☐ Part Time ☐ Not a Student
Employer:		Job Title
Address:		
City, State, Zip		Phone: ( )
Physician Name:		

COMPLETE IF VISIT IS DUE TO AN INJURY

Employment Related: ☐ Yes ☐ No	Accident Related: ☐ Auto ☐ Other ☐ No	Date of first symptom or accident:

INSURANCE INFORMATION

Primary Insurance Company Name	Mailing Address
Insurance Telephone #	Group/ID #
Secondary Insurance Company Name	Mailing Address
Insurance Telephone #	Group/ID #

COMPLETE IF INSURANCE IS IN SPOUSE'S OR PARENT'S NAME

Last Name	First Name	Middle Initial
Address	Social Security #	

Date of Birth	Gender ☐ Male ☐ Female	Employer:	Patient Relationship to Insured: ☐ Spouse ☐ Child ☐ Other

Authorization for release of medical information: I authorize the release of any medical information necessary to process this claim.
Authorization of payment: I authorize payment of medical benefits directly to The Physical Therapy Center, Ltd. for services rendered.
Patient responsibility: The patient is ultimately responsible for payment of all fees for physical therapy services provided, regardless of whether the patient maintains coverage with a private insurance company. The Physical Therapy Center, Ltd. will bill the insurance company with the patient responsible for immediate payment of those fees which the private insurance company does not pay, unless prior arrangements have been made with TPTC.

I agree to the above stated terms: Signature: ____ Date: ____/____/_____

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WORKERS COMPENSATION

Last Name	First Name	Middle Initial
Social Security #	Date of Birth	Gender ☐ Male ☐ Female

Last Day Worked:
Claim #
Adjuster:
Rehab Nurse:
Company Name:
Address:
City, State, Zip

Phone: ( )	Fax: ( )

LEGAL INFORMATION

Attorney:
Address:
City, State, Zip

Phone: ( )	Fax: ( )