GREAT DIVIDE
PHYSICAL THERAPY

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406-317-1875 (Fax)
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PATIENT INFORMATION FORM

Name: First _____ Middle I. _____ Last _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Home Address

_____

_____

Mailing Address (Or Same)

_____

_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Appointment Reminder Method:

☐ Text To: _____ ☐ Phone To: _____

Injury or Symptom Onset Date: _____

Injury Cause: ☐ Auto Accident ☐ Workman's Comp Injury ☐ Other (Describe) _____

Referring physician: _____ Other referring source: _____

PRIMARY INSURANCE

☐ I choose to have my insurance card photocopied instead of completing the following

Policy Holder Info (If patient is not the subscriber)

Name: _____

Date of Birth: _____

SECONDARY INSURANCE (If Applicable)

☐ I choose to have my insurance card photocopied instead of completing the following

Policy Holder Info (If patient is not the subscriber)

Name: _____

Date of Birth: _____

INSURANCE AUTHORIZATION (Please Initial)

_____ I authorize payment of medical insurance benefits directly to Great Divide Physical Therapy and I accept responsibility for payment of services not covered by my insurance.

INFORMATION RELEASE CONSENT (Please Initial)

_____ I consent to the release of any confidential medical information collected by Great Divide Physical Therapy to my physicians and my medical insurance companies.

CONSENT TO TREAT FOR MINORS (Please Initial)

_____ As parent and/or legal guardian, I authorize and give my consent for Great Divide Physical Therapy to provide treatment to _____ (minor's name).

RECEIPT OF PRIVACY NOTICE (Please Initial)

_____ I have received a copy of and understand the PRIVACY NOTICE provided to me by Great Divide Physical Therapy.

Signature: _____ Date: _____