

# Lighthouse Physical Therapy, LLC

## Patient Information

Welcome! Thank you for selecting our practice. In order to serve you properly, we need the following information. All information will be strictly confidential. (Please Print)

Patient Name: \_\_\_\_\_ Date of Birth (M/D/YR) \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Home (Street # & Name) City State Zip

Address \_\_\_\_\_  
Mailing (If Different then above) City State Zip

Confirmation calls/Messages-the Best Phone # to reach you \_\_\_\_\_ Second Choice \_\_\_\_\_  
(Please circle) Home/Work/Cell Home/Work/Cell

Urgent/Wait list calls-the Best Phone # to reach you (if not the same as above) \_\_\_\_\_  
(Please circle) Home/Work/Cell

Check appropriate boxes: Male  Female  Minor  Single  Married  Separated  Divorced  Widowed

If Minor, Parent/Guardian's Name: \_\_\_\_\_ Employer \_\_\_\_\_  
First Last

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
First Last

### Responsible Party

Person responsible for this account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (If different from above) \_\_\_\_\_

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

Employer's Address \_\_\_\_\_ Occupation \_\_\_\_\_

### Insurance Information

Name of Insured (Subscriber): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth (Subscriber): \_\_\_\_\_ SS# (Subscriber): \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group #/Plan Code: \_\_\_\_\_

**Do you have any additional insurance? Yes  No  if yes, complete the following:**

Name of Insured (Subscriber): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth (Subscriber): \_\_\_\_\_ SS# (Subscriber): \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group #/Plan Code: \_\_\_\_\_

Is condition work related? Yes  No

Is condition due to an automobile accident? Yes  No

Date injury occurred \_\_\_\_\_

Date of accident or injury \_\_\_\_\_ State \_\_\_\_\_

Insurance Name or  
Workman's Comp \_\_\_\_\_ Claim # \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

### Authorization & Release

I certify that the above information is correct and I understand that I am financially responsible for all charges for service to me (or my child), including the balance remaining after payment of possible insurance benefits. I understand that payment is expected for any co-pay's, deductibles and/or balances owed on the day of each treatment, with the exception of Worker's Compensation insurance coverage. I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Lighthouse Physical Therapy.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_