ENCORE
PHYSICAL THERAPY

Todays Date_____

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

Date of Birth:_____/_____/_____ **Male** ☐ **Female** ☐ **Social Security #**_____

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 Provider:_____ **Telephone:**_____

Primary Provider:_____ **Telephone:**_____

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