PHYSICAL & SPORTS THERAPY SERVICES OF ST. LOUIS

950 FRANCIS PLACE, STE. 15, ST. LOUIS, MO 63105 (314) 726-1186

PATIENT'S **LEGAL NAME** (PLEASE PRINT) REFERRED BY: _____

NAME_____ **DATE OF BIRTH**_____

ADDRESS_____ CITY_____ ST._____ ZIP_____

EMAIL ADDRESS_____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____ SS #_____ SINGLE / MARRIED/ OTHER

DATE OF INJURY/SYMPTOM_____ ACCIDENT: NONE / AUTO / OTHER / WORKER'S COMP

PERSON RESPONSIBLE FOR ACCOUNT_____ RELATIONSHIP_____

PHONE_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____

EMPLOYER_____ WORK PHONE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

REFERRING PHYSICIAN_____ PH#_____ NEXT APPT DATE_____

PRIMARY INSURANCE_____ EMPLOYER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SUBSCRIBER_____ RELATIONSHIP_____ DATE OF BIRTH_____

GROUP #_____ ID#_____ **AUTH#**_____

SECONDARY INSURANCE_____ EMPLOYER_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SUBSCRIBER_____ RELATIONSHIP_____ DATE OF BIRTH_____

GROUP #_____ ID#_____

I AUTHORIZE THIS CLINIC TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT INCLUDING MEDICAL RECORDS. I PERMIT PAYMENT DIRECTLY TO THEM AT THEIR ELECTION, ANY BENEFITS DUE ME FOR THEIR SERVICES. I RECOGNIZE AND ACCEPT PERSONAL RESONSIBILITY FOR ANY BALANCE REMAINING AFTER PAYMENT OF SUCH BENEFITS.

SIGNATURE:_____ DATE:_____