Physical Therapy of Central Virginia

Orthopedic and Sports Physical Therapy

Patient Information	Today's Date: / /
First Name	Last Name M.I. Age
Address	City State ZIP
Birth Date / /	SSN - - Marital Status ___S ___M___W
___Male ___Female	Home Phone ( ) - Cell Phone ( ) -
Email:	
Chose Clinic Because ___Dr. Referred ___Friend/Family Referred ___Website ___Insurance Plan	
___Return Patient ___Advertisement ___Location	
Work Information	
Employment Status ___Full ___Part ___Retired ___Not Employed	Employer
Work Phone ( ) -	Ext. Occupation
School Information	
Are you a student? ___Yes ___No	Name of School:
Did you get hurt at school? ___Yes ___No	Playing what sport:
Physician Information	
Referring Doctor	Family Doctor
Can we share your records with your family doctor? ___Yes ___No	
Insurance Information	
Primary Insurance Name	Secondary Insurance Name
Subscriber Name	Relationship to Patient ___Self ___Spouse ___Parent
Subscriber Date of Birth / /	Subscriber SSN: - -
In Case of Emergency	
Name of local friend or relative	Relationship
Home Phone ( ) -	Work Phone ( ) -
Financially Responsible Party (If patient is a minor please make sure to fill in all information)	
Name	Date of Birth / / SSN - -
A laminated copy of our **Notices of Privacy Practices** is available for you to read in our lobby. We are more than happy to provide you with a copy for your records. Just ask the receptionist.	
Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. I, _____ (please print patient name), have reviewed a copy of Physical Therapy of Central Virginia's (PTCVA) Notice of Privacy Practices. I understand that I may ask questions to PTCVA if I do not understand any information contained in the Notice of Privacy Practices.	
_____ Patient/Guardian Signature	_____ Date