



advanced
physical
therapy

creating an environment for wellness and healing

Last: _____ First: _____ Middle Int: _____ Today's Date: _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: ____/____/____ Social Security #: ____ - ____ - ____ Home Phone: _____
 CellPhone: _____ Do you want a reminder call? Yes No Which # is best to reach you at: Work Home Cell
 Male _____ Female _____ Marital Status: Single _____ Married _____ Other _____
 Spouse's Name: _____ Date of Birth: ____/____/____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Patient's Current Employer: _____ Phone: _____
 Referring Physician: _____ Reason for visit: _____
 How did you hear about us? (check any that apply) Physician ____ Yellow Pages ____ Ad ____ Presentation ____ Friend ____ Event ____ Other ____

PRIMARY INSURANCE

Primary Insurance Carrier: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Policy #: _____ Group#: _____
 Guarantor/Policy Holder Name: _____
 Relationship: _____ Date of Birth: ____/____/____

SECONDARY INSURANCE

Secondary Insurance Carrier: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Policy #: _____ Group#: _____
 Guarantor/Policy Holder Name: _____
 Relationship: _____ Date of Birth: ____/____/____

WC or Auto

Insurance Company: _____ Claim#: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Adjuster's Name: _____ Phone: _____
 Date of Injury: ____/____/____ Employer at Time of Injury: _____ Accident State: _____
(WC or Auto Only) (WC Only) (Auto Only)

**PLEASE PAY COPAY AT EVERY VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.
 FOR ANY BILLING QUESTIONS 907-743-8228 OR 800-641-6940.**

I understand that I am responsible for all fees regardless of insurance coverage and that all charges are due at time of service. I am responsible for furnishing all insurance information correctly prior to treatment unless other arrangements have been made in advance. I authorize advanced physical therapy to examine me, administer treatment as necessary and perform procedures that are considered therapeutically or diagnostically necessary.

Signature _____ Date _____