Wilson Physical Therapy S.C.
400 3rd Avenue West, Suite 100
Ashland, WI 54806-1610

Patient In-Take

Patient Name:_____ **Social Security #**_____
(First) (M) (Last) **Date of Birth:**_____
Today's Date:_____
Referring Physician:_____

How did you hear about Wilson Physical Therapy?
Family Member ___ Friend ___ Doctor ___ Yellow Pages ___ Other _____

Government Mandated Information:
Please check one: Female ___ Male ___
Marital Status: Married ___ Single ___ Divorced ___ Widow(er) ___ Other _____
Ethnicity: Hispanic/Latino ___ Non-Hispanic/Non-Latin ___ Unreported/Refused ___
Race: White ___ American Indian ___ Asian ___ Black/African American ___
Other _____ Unreported/Refused ___

Home Address_____ **City:**_____ **State:**_____ **Zip**_____
Home Phone #_____ **Cell #**_____ **Evening Phone #**_____
Emergency Contact:_____ **Home Phone:**_____ **Cell Phone:**_____

Current Employer:_____ **Employer Address:**_____
Employer Phone #:_____ **Is it okay to contact you at work? ____Yes ____No**

Please provide insurance card at registration

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Designated Individuals Authorization

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment, or administration operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ **Relationship**:_____
Name: _____ **Relationship:**_____
Name: _____ **Relationship:**_____

Patient Signature: _____ **Date:** _____

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Auto Accident/ Workman's Compensation/Liability

Is this case a result of an accident? Yes/no (circle one) ***If yes, please fill out the rest of this section.***
Date of Injury/Accident_____
Injury due to an: Work Injury? Yes ___ No ___ Auto Accident? Yes ___ No ___ Liability? Yes ___ No ___
Do you have a case manager? Yes ___ No ___ Case Manager's Name:_____
Case Managers Phone Number:_____

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Complete only if Patient is a MINOR

Mother's Name:_____ **Date of Birth:**_____
Father's Name:_____ **Date of Birth:**_____

Address of Responsible Party if Different from Above:
Address:_____ **City/State/Zip**_____ **Phone** _____