- 5909 W. State St.
- Boise, ID 83703
- P: (208) 343-7700
- F: (208) 331-2591
- *info@pt180boise.com*

PATIENT INFORMATION:

Name ____
(Last) (First) (MI)

Sex: ❑M ❑F Age ______ DOB: _______/________/________

Cell Phone:______________________________Home (Land Line):_________________________

Address ____

City ____________________________________ State _____________ Zip ________________

May we e-mail you with upcoming events: ☐ No ☐ Yes: email address______________________

Employer ___________________________________ Occupation: ___________________________

Employer Address _________________________________ Emp. Phone _______________________

In Case of Emergency _____________________________________ Phone_ ___________________

Referring Physician's Name: ____

Is there a Physician you want us to update on your therapy: ☐ Yes **(go to next line)** ☐ No

Physician Name:_____________________________Clinic: __________________________________

How did you hear about us: ☐ internet ☐ radio ☐ friend ☐ Dr. ☐ phone book

☐ other:____

INSURANCE INFORMATION:

☐ Insured ☐ Medicaid/Medicare ☐ Worker's Comp ☐ Car Accident ☐ Self-Pay ☐ Liability

Primary Ins:____ID:_______________________________

Secondary Ins: _______________________________________ID:_______________________________

Tertiary Ins:____ID:_______________________________

Subscriber Name:__________________________***DOB:***___/___/___***Relationship:***______________

Subscriber Address:____

(if different than patient or patient is minor)

(circle one)
Date of Injury/Onset:________________________Date of surgery:___________________________

Aduster Name:_________________________________Phone:________________________________

I, the undersigned certify that all the above information is correct and I will inform the office of any changes as they occur.

Signature____Date:____________________________
(Parent or legal guardian if minor)