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 (If none, N/A):_________________________

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/social media ❑radio ❑friend ❑Dr. ❑in-network insurance

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)