CORNERSTONE PHYSICAL THERAPY

PATIENT INFORMATION

First name____________________ Last name_____________________ Preferred name___________________

DOB______________ Patient/Guarantor SSN#_________________________________

Email address____________________________ Marital Status: ☐Single ☐Married ☐Other ______________

Street Address____ City___________________________________

State_________ Zip Code_____________

Primary phone__________________________ Alternate phone______________________________

Emergency Contact Name________________________ Phone______________ Relationship_______________

How did you hear about Cornerstone PT? ☐ Friend/Family ☐ Referral ☐ Internet ☐ Other___________

How would you like to receive appointment reminders? ☐ Email ☐ Text ☐ Phone Call ☐ Decline Reminder

Primary Care Provider____________________________ Referring Provider (if different)___________________

Medical Diagnosis or Primary Concern for visit____

Is the pain or injury above related to a motor vehicle accident or work related accident?______________________

If yes, choose ☐Motor vehicle accident ☐ Work accident Date of accident___________________________

INSURANCE/GUARANTOR INFORMATION ☐Bill insurance policy ☐Self pay $65.00

Insurance Name______________________________ Policy/ID#______________________________________

Policy Holder Name____ DOB__________________

Copay____________ Deductible_______________ Amount due if deductible is not met________________

Coinsurance amount due if deductible is met_________________ Visit limit_________________

Relationship to patient____________________ Policy holder SSN_________________________

Secondary Insurance Name_____________________________________ Policy/ID#________________________

CONSENT FOR EMAIL AND/OR TEXT COMMUNICATION

I, the undersigned, give permission to Cornerstone Physical Therapy, to communicate with me via email and/or text. I understand that Cornerstone Physical Therapy cannot guarantee the security of Protected Health Information (PHI) if I request it via email. I understand that Cornerstone Physical Therapy will respect my privacy and will only send information related to my diagnosis, appointments, special events and snow closures.

☐ Yes, I give my consent to use email communications ☐ text communications (please check one or both boxes)

☐ No, I do not give my consent to use email communications ☐ text communications (please check one or both boxes)

______________________________________ ____________________________

Signature of Patient (or Legal Guardian) Date