PATIENT DEMOGRAPHIC FORM

Meyers Physical Therapy
2311 Lake Tahoe Blvd, Suite 1, South Lake Tahoe, CA 96150

Last Name	First name	MI	DOB	SSN#
Mailing Address			City, State, Zip	
Home Phone	Work Phone	Cell Phone	Gender	Marital Status
Email Address			Can we send you Newsletters, Health Articles, and Updates? Yes □ No □	
Employer	Employer Address		City, State, Zip	

Responsible Party Information(if different from above)

Last Name	First name	MI	DOB	SSN#
Mailing Address			City, State, Zip	
Home Phone	Work Phone	Cell Phone	Gender	Marital Status

Primary Insurance

Name of Insurance/Worker's Comp			Policy/Claim#
Name of Insured	DOB	SSN#	Group#
Address of Insurance Company			City, State, Zip
Relationship to Patient	Effective Date	Copay	Deductible
Adjustor's Name	Adjustor's Phone		Adjustor's Fax

Secondary Insurance

Name of Insurance			Policy/Claim#
Name of Insured	DOB	SSN#	Group#
Address of Insurance Company			City, State, Zip
Relationship to Patient	Effective Date	Copay	Deductible

Accident or Injury Information

Referring Physician	Phone	Primary Care Physician	Phone
Diagnosis/Injury			
Accident □ Workers Comp □ Auto□ Slip/ Fall □		Accident/ Injury Date	Other Specified:
Employment Related Current □ Previous □			Type of Work
Employer	Employer Address		City, State, Zip

How did you hear about us? Family □ Friend □ Doctor □ Newspaper □ Internet □ Other □

Are you currently in Home Health? Yes □ No □ **Did you have Home Health, If Yes when?** _____

I herby authorize the release of any information relating to all claims for insurance benefits submitted on behalf of dependants or myself. I further authorize the release of records pertaining to dependants or myself to other physicians, or ancillary services (including but not limited to: prosthetic/orthotic/assistive device services, therapies, or home health). I give permission to contact me at my address, by telephone, or email given in medical records. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED AND RECEIVED.** A penalty may incur for late payment, returned checks, or failing to attend scheduled appointment.

X_____
Signature of Patient or Responsible Party Date