



HANDS ON
PHYSICAL THERAPY, PC

1441 SW Chandler Avenue Suite 103 · Bend, Oregon 97702
TEL: 541.312.2252 · Fax: 541.312.8822

PATIENT INFORMATION

Name: _____ Today's Date: _____
Last Name First Name MI

Address: _____ Home Phone #: () _____

City: _____ State: _____ Zip: _____ Cell Phone #: () _____

Date of Birth: _____ Age: _____ Sex: Male Female E-mail: _____

Social Security #: _____

Patient Employer/School _____ Occupation _____

Employer/School Phone () _____

How did you hear about us? Friend/Family Member Doctor Website Phonebook

Whom May We Thank for Referring You? _____

Emergency Contact Information:

Name: _____ Relationship: _____

Home Phone#: () _____ Work Phone#: () _____ Cell Phone#: () _____

INSURANCE INFORMATION

Name of Subscriber _____

Relationship to Patient _____ Subscriber's Date of Birth _____

Is Patient Covered by Additional Insurance? Yes No

ACCIDENT/INJURY INFORMATION

Is your injury due to: On-the-job injury? YES NO Motor vehicle accident? YES NO

If you answered "YES" to either of the above, please complete the following:

Date of Accident: _____

Insurance Company: _____ Adjuster's Name: _____

Phone #: () _____ Claim #: _____

Address: _____
Street City State Zip