EXPERIENCE EVERY DAY.

Alpine Physical Therapy & Spine Care

Last Name _____ First Name _____ MI _____ Nickname/Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ E-Mail _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Employer Name and Address _____

Emergency Contact _____ Relationship to Patient _____ Phone Number _____

How did you hear about APT? Who referred you to our office?_____

Your benefits may be affected by previous treatment elsewhere (visit limits, authorizations, etc) Please note the number of physical therapy visits you've had this year at any other locations: _____

If patient is under age 18, please complete the following:

Name of Parent or Guardian _____ Parent or Guardian SSN _____ Parent or Guardian Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Work Injury / Accident Information, please complete the following if applicable:

Accident Date _____ Claim Number _____ Accident Insurance Co. _____

Address _____ Adjuster Name _____ Adjuster Phone _____

Attorney Name & Phone Number, if applicable _____

- - FOR OFFICE USE ONLY - -

Verification Date _____ Insurance _____ Phone _____

Policy/ID Number _____ Group Number _____ Effective Date _____ Auth Required _____

Deductible (met) _____ Coverage/Co-pay _____ Visit Limits _____ Visits Used YTD _____

Authorization/Coverage/Exclusion Details: _____