Endurance
PHYSICAL THERAPY

Patient Demographics

Patient's Name:		Appointment Date:
Billing Address:		
Home Phone:	Cell Phone:	Work Phone:
DOB:	SS#:	Email: ☐ Yes, sign me up for the EPT Newsletter
Gender: ☐ Female ☐ Male	Marital Status: ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Single	
Employer:	Work Status: ☐ Full Time ☐ Part Time ☐ Not Working ☐ Retired ☐ Other	
Emergency Contact Name/Relationship:		Phone:
How did you hear about us? *Be specific and we will send them a Thank You card.		

Insurance Information

Primary Insurance:	
Subscriber's Name:	Subscriber's DOB:
ID Number:	Group Number:
Secondary Insurance:	
Subscriber's Name:	Subscriber's DOB:
ID Number:	Group Number:

Motor Vehicle Accident/Worker's Compensation Insurance

Date of Accident:	☐ Auto ☐ Work ☐ Other:	State in which accident occurred:
Insurance Company (Auto PIP or W/C):		Claim Number:
Address:	Claims Adjuster:	Phone Number:

Signature

I verify that the above information is accurate.

X_____