PATIENT INFORMATION

Referred by: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Sex: Male / Female Social Security Number: _____ Marital Status: Married / Single / Other

Address: _____City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Employer: _____

Email Address:_____

Emergency Contact :_____ Telephone: _____

Guarantor (if different from patient)

Name: _____ Date of birth: ___/___/___ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Alternate Phone: ( ) _____

Social Security Number: _____

Employer Name: _____ Phone Number:_____
Address:_____

Y N Are you a student athlete?
Y N Did your injury occur at work?
Employers Information: _____
Y N Was your injury related to an automobile accident?
Y N Litigation pending?

Date of injury: ___/___/___
Details of injury:

_____

❑ _____ **(Initial) Release of information:**
I give permission to OMPT, Inc. and its affiliates to release information, both verbal and written, contained in my medical record, and other relate information, to my insurance company, case manager, attorney, employers, school, related healthcare providers, assignees and/or beneficiaries and any other related persons. Information without patient identifiers may be used for quality purposes.

❑ _____ **(Initial) Assignment of Benefits / Payment Guarantee:**
I agree to pay OMPT, Inc. and/or its affiliates for the services provided to me or the party named above. If the law (i.e., Workers compensation) my payor contract prohibits my payment for these service I will cooperate and or assist in the provision of information, releases, etc. to allow for quick collection from my third party payor. I authorize payment directly to OMPT, Inc. and its affiliates for services. Where the law or a payor contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

Consent for treatment:
All information is true and correct. I hereby consent to the recommended treatment.

_____ _____
Signature Date

* All individuals shall be accorded impartial access to treatment regardless of race, gender, national origin, disability, health status, religion, age, sexual orientation, or sources of payment for care.