Verified DL/Photo ID ☐
Verified Insurance Card(s) ☐

HORST PT
Strength. Mobility. Function.

Patient Information Form

First Name: _____ Last Name: _____ Sex: ☐F ☐M
DOB: _____ Status: ☐Single ☐Married ☐Other SSN: _____
Phone/Cell: _____ Email: _____ ☐Declined Email
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone: _____

Ref. Physician: _____ Phone: _____ RX Date: _____

Employer: _____ Status: ☐FT ☐PT ☐None ☐Retired ☐Student
Occupation: _____

Injury/Onset Date: _____ Body Part/DX: _____
Post-Surgical: ☐Yes ☐No Surgery Date: _____
Have you had prior therapy this year (PT/OT/ST/Chiro): ☐Yes ☐No If yes, how many: _____
How did you hear about us? _____

Work Related: ☐Y ☐N | Accident Related: ☐Y ☐N | Auto Related: ☐Y ☐N | Attorney Involved: ☐Y ☐N
Adj/Nurse Case Mgr.: _____ Phone: _____
Attorney: _____ Phone: _____

If Medicare, are you currently Receiving Home Health Services? ☐Yes ☐No
If YES, Name of Agency: _____ D/C Date: _____

Insurance: _____ Plan: _____
Policy ID#: _____
Group #: _____ Auth: ☐Y ☐N
Phone: _____
Subscriber: _____ DOB: _____
Relation to Subscriber: ☐Self ☐Spouse ☐Child

Insurance: _____ Plan: _____
Policy ID#: _____
Group #: _____ Auth: ☐Y ☐N
Phone: _____
Subscriber: _____ DOB: _____
Relation to Subscriber: ☐Self ☐Spouse ☐Child

Please sign if the above information is correct and complete.

x: _____ Date: _____