

Whitefish Therapy & Sport Center

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____
Address _____
Address2 _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____
First Name _____ Phone _____

Employer

Name _____ Phone _____
Address _____
Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit ____/____/____
Referred By _____ Primary Care Physician _____
Latest Referral Information _____ Motor Vehicle Accident _____
Latest Plan of Care _____ That occurred in: _____
Notes: _____

Primary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	CoInsurance _____	Date of Birth _____

Secondary Insurance

Insurance _____	Deductible _____	Subscriber Name _____
ID _____	Max Benefit _____	Relationship _____
Group # _____ CoPay _____	CoInsurance _____	Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. Contact Ashley McGuire @ 406-862-9378.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____