5909 W. State St.
Boise, ID 83703
P: (208) 343-7700
F: (208) 331-2591
info@pt180boise.com

2690 S. Eagle Rd.
Meridian, ID 83642
P: (208) 898-1468
F: (208) 331-2591
info@pt180boise.com

PATIENT INFORMATION:

Name _____
(Last) *(First)* *(MI)*
Sex: ❑M ❑F Age _____ DOB: _____/_____/_____

Cell Phone:_____Home (Land Line):_____

Address _____

City _____ State _____ Zip _____

May we e-mail you with upcoming events: ☐ No ☐ Yes: email address_____

Employer _____ Occupation: _____

Employer Address _____ Emp. Phone _____

In Case of Emergency _____ Phone_ _____

Referring Physician's Name: _____

Is there a Physician you want us to update on your therapy: ☐ Yes **(go to next line)** ☐ No

Physician Name:_____Clinic: _____

How did you hear about us: ☐ internet ☐ radio ☐ friend ☐ Dr. ☐ phone book

☐ other:_____

INSURANCE INFORMATION:

☐ Insured ☐ Medicaid/Medicare ☐ Worker's Comp ☐ Car Accident ☐ Self-Pay ☐ Liability

Primary Ins:_____ID:_____

Secondary Ins: _____ID:_____

Tertiary Ins:_____ID:_____

Subscriber Name:_____***DOB:___/___/___Relationship:***_____

Subscriber Address:_____

(if different than patient or patient is minor)

(circle one)
Date of Injury/Onset:_____Date of surgery:_____

Aduster Name:_____Phone:_____

I, the undersigned certify that all the above information is correct and I will inform the office of any changes as they occur.

Signature_____Date:_____
(Parent or legal guardian if minor)