PATIENT INFORMATION FORM

The Sigurd Center for Orthopedic & Neurological Rehabilitation

1311 Augusta Road West Columbia, SC 29169
P: 803. 926.7204 F: 803.926.7206
www.sigurdphysicaltherapy.com

Please provide your insurance card(s) and a valid picture ID along with patient information form

Personal Information

Last Name:__________ First Name:__________ Middle Initial:__________

Date of Birth:__________ Marital Status: S M W D SEP Sex: M F

Address:__________ Apt. #_____ City:__________ State:_____ Zip:__________

Telephone Home:__________ Cell:__________ Work:__________

Social Security Number:__________ Referring Physician__________

Emergency Contact:__________ Phone #:__________ Relation to Patient:__________

Spouse/Parent's Name:__________ Spouse/Parent's SS#:__________

Spouse/Parent's DOB:__________ Spouse/Parent's Phone #__________

If you have been referred by a doctor other than your primary care physician/internist, please fill out the following section.

Primary Care Physician __________ Internist __________

Cardiologist __________ Neurologist __________

Any other MD(s) you are under the care of at this time. __________

Are you currently receiving ANY type of home health services? Y N

Is your injury related to a car accident? Y N If so, do you have a lawyer or are you under litigation? Y N

Has your injury resulted in litigation? Y N If yes, please fill out the following information below:

Lawyer:__________ Law Firm:__________ Phone#:__________

Employer:__________ Occupation:__________ Phone #:__________

Insurance Information

1. Primary Insurance:__________ Insured Name:__________
2. Secondary Insurance:__________ Insured Name:__________
3. Tertiary Insurance:__________ Insured Name:__________

If Medicare is your primary insurance, has a crossover been set-up with your secondary insurance? Y N

Whom do we have the pleasure of thanking for referring you to us? __________

Patient Signature: __________ **Date:** __________