

**LAKESIDE
PHYSICAL THERAPY
REHAB and
SPORTS MEDICINE**



Patient Name: _____ Date of Birth: ____/____/____
Last Name, First Name, Middle Initial

Social Security Number: ____/____/____ Male ____ or Female ____

Phone: _____ Cell Phone.- _____ Work Phone: _____

Permanent Address: _____ City: _____

State: _____ Zip Code: _____ From _____ (month) to _____ (month)

Local Address: _____ City: _____

State _____ Zip Code- _____ From _____ (month) to _____ (month)

Primary Insurance: _____

ID#: _____ **Group#:** _____

Subscriber: _____

Date of Birth _____ SSN _____ **Copay** _____

Secondary Insurance: _____

ID#: _____ **Group#:** _____

Subscriber: _____

Date of Birth _____ SSN _____ **Copay** _____

Patient's Employer: _____

Insured's Employer: _____

Emergency Contact: _____ Phone Number: _____

Relationship to patient: _____

Who may we thank for referring you? _____

PLEASE READ THE FOLLOWING CAREFULLY, SIGN AND DATE:

I AUTHORIZE MY TREATING PHYSICIAN TO RELEASE MY MEDICAL RECORDS TO MY PHYSICIAN, TO THE MEDICAL PROVIDER WHO REFERRED ME, AND TO THE MEDICAL PROVIDERS YOU MAY REFER ME TO OR CONSULT WITH ON MY BEHALF. I AUTHORIZE YOU TO RELEASE ANY MEDICAL INFORMATION NECESSARY FOR PROCESSING INSURANCE CLAIMS. I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE BENEFITS TO YOU AND I AGREE TO PROMPTLY PAY AMOUNTS NOT COVERED BY THEM. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PLEASE PRINT PATIENT'S NAME

PATIENT OR GUARDIAN'S SIGNATURE

DATE _____