

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Street Address: _____ Zip: _____ City _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Would you like appointment reminders by text message to your cell phone? Yes No

E-mail: _____ Would you like appointment reminders by e-mail? Yes No

Birth Date: _____ Age: _____ Gender: Male Female

Race (Circle): American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian / Other Pacific Islander / White / Decline to State

Ethnicity (Circle): Hispanic or Latino / Non Hispanic or Latino / Decline to State Marital Status (Circle): Single / Married / Separated / Divorced / Widowed

Employer: _____ Employment Status (Circle): Full-time / Part-time / Not Working / Retired

Employer's Address: _____ Phone: (____) _____ Occupation: _____

Emergency Contact Name: _____ Phone: (____) _____ Relationship: _____

How did you hear about Mosaic Physical Therapy? _____

Areas to be treated: _____

Primary Insurance: _____ Insured Name: _____ Insured's SS# _____

Secondary Insurance: _____ Insured Name: _____ Insured's SS# _____

Referring Physician Name: _____ Phone: Phone: (____) _____ Address: _____

Mosaic Physical Therapy is a fee for service office

Each patient is responsible for any and all fees incurred

I authorize Mosaic Physical Therapy to release to my insurance company any and all information required to process my insurance claim

Assignment: I hereby assign my insurance benefits payment to be made directly to Mosaic Physical Therapy. I am responsible for the payment of any uncovered services. I have read and agreed to all of the above.

Signature: _____ Date: _____