



Atrium Physical Therapy Client Information

Patient Name _____ Birth Date: _____
Phone Number: _____ May we send text messages? **Y N** Voice mail messages? **Y N**
Email: _____
Emergency contact: Name: _____ Telephone: _____
Relationship to patient: _____
Do you have Advance Directives? **Y N** If so, please provide us with a copy for our file.
Referring doctor: _____
Date of last doctor's appointment: _____ Date and time of next appointment: _____
Have you had any diagnostic studies or tests done for this current problem?

☐ CT scan ☐ MRI ☐ Other _____

Date and Place test: _____

Date and Place test: _____

Why did you choose to come to us? Check all that apply.

☐ Internet ☐ I am a past patient ☐ insurance provider list ☐ Location ☐ Phone Book
☐ Doctor ☐ Friend ☐ Other _____

If doctor or friend whom can we thank? _____

Medicare Only

Are you currently, or have you recently, received care from a home health agency? **Y N**
If you are currently receiving Home Health services, speak to the front desk staff.

Workers Comp only

Employer Name: _____ Telephone: _____

Date of Injury: _____

Authorization to Release Information

I authorize Atrium Physical Therapy, Inc. to release any information (current and/or past medical information, billing, appointments, etc.) about myself to the following:

_____ I do not want information released to anyone

_____ OK to release information to Emergency Contact above (please initial)

Name: _____ Relationship: _____
Please Print

Name: _____ Relationship: _____
Please Print

Name: _____ Relationship: _____
Please Print

Signature: _____

Office Use Only: Initials of receipt: _____ Date: _____