☐ **Hartland**
600 Hartbrook Drive
Hartland, WI 53029
P: 262-367-3110
F: 262-367-3112

Patient's Name: _____ (____) _____ (____) _____
Last First MI Home Phone Cell Phone

Home Address: _____
Street City State Zip

Birth Date: _____
MM/DD/YY Age Sex Marital Status

Patient's Employer: _____ (____) _____
Phone

Address: _____
Street City State Zip

Email: _____

How were you referred to the clinic: ☐ Doctor ☐ Friend ☐ Ins. Co. ☐ Yellow Pages ☐ _____

COMPLETE IF PERSON RESPONSIBLE FOR BILLING OTHER THAN PATIENT

Policy Holder's Name: _____ DOB: _____ SS#: _____ _____
MM/DD/YY or Copy of Driver's License Relationship

Policy Holder's Address: _____
Street City State Zip Phone

Policy Holder's Employer: _____ (____) _____
Phone

Employer's Address: _____
Street City State Zip

COMPLETE IF INJURY IS ACCIDENT RELATED

Injury related to: _____ W/C _____ MVA _____ State _____ Other Injury Date: _____
W/C or Auto Insurance: _____ Claim #: _____
Address: _____
Adjuster: _____ Phone: _____ Are you Presently Working? _____

INSURANCE INFORMATION - PLEASE SHOW INSURANCE CARD TO RECEPTIONIST

First Insur. Name: _____ Policy Holder: _____
ID #: _____ GPR# _____
Second Insur. Name: _____ Policy Holder: _____
ID #: _____ GPR# _____

I REQUEST TREATMENT FOR MYSELF OR MINOR CHILD FROM WPTC & ASSIGN ALL MEDICAL BENEFITS TO WHICH I OR MY DEPENDENTS ARE ENTITLED UNDER MY HEALTH INSURANCE.

I acknowledge that Waukesha Physical Therapy Clinic has given me a copy of its Notice of Privacy Practices, and the chance to discuss my concerns about my health information. _____*(initial)*

_____ _____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE

(FOR OFFICE USE ONLY)
Referring Dr.: _____ Primary Dr.: _____ 1st RX _____
DX Code: _____ Description: _____ Eval PT: _____
Auth. #: _____ # Visits: _____ Dates: _____ Prev. Ther. Visits: _____
Medi POC OR Benefits: _____ By: _____
Deduct: _____ Co-Pay: _____ Coinsur: _____ Payment EA Visit: _____