



*Physical Therapy Group*  
*Professional • Quality • Care*

Ph 502.493.3800  
4233 Bardstown Rd, Suite 100-C

Fax 502.493.3803  
Louisville, KY 40218

**Confidential Patient Information  
(Please Print Legibly)**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone:(Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: M F Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

**Person Responsible for Account if different from above**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

SSN: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medical Insurance Information**

Primary Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I understand that payment is my obligation regardless of insurance or any other 3<sup>rd</sup> party involvement.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_