Londonderry Physical Therapy / Pinnacle Rehabilitation Network, LLC

Patient Information

Patient's Name: ______________________ DOB: ______________ SSN: ______________ Sex: M F

Mailing Address: ______________________ City/State/Zip: ______________________

Primary PH#: ______________ Cell ☐ Home ☐ Other ☐ Secondary PH#: ______________ Cell ☐ Home ☐ Other ☐

Preferred Method for Reminders (Circle One): **Call:** Primary/ Secondary **Text:** Primary /Secondary **No Reminder**

Email: ______________________ How did you hear about us? ______________________

Emergency Contact: Name______________________ PH#______________ Relationship: ______________

Reason for Referral: ______________________ Is the injury related to (circle one): Work/Auto /Neither

Referring Provider: ______________________ Primary Care Provider: ______________________

Primary Insurance

Insurance: ______________ ID# ______________ **Is the Policy Holder a RETIRED Federal Employee:** Yes/No

Policy Holder: Name: ______________________ Relationship to Insured: ______________ DOB: ______________

Street Address: ______________________ City/State/Zip: ______________________ PH#: ______________

Secondary Insurance

Insurance: ______________ ID# ______________ **Is the Policy Holder a RETIRED Federal Employee:** Yes/No

Policy Holder: Name: ______________________ Relationship to Insured: ______________ DOB: ______________

Street Address: ______________________ City/State/Zip: ______________________ PH#: ______________

Workers Compensation/Auto Carrier

Worker's Comp/Auto Carrier: ______________________ Claim Number: ______________________

Contact Name: ______________________ Contact Phone Number: ______________________

Employer: ______________________ PH#: ______________________

IMPORTANT: For an auto accident, we can only send claims to the insurance company of the car you were in at the time of the accident; we cannot send claims to the insurance company of the other party involved. Do not provide insurance company of other party involved.

Attorney Information

Contact Name: ______________ Contact PH#: ______________ Contact Fax#: ______________

Financially Responsible Party/Guarantor-Other Than Patient or Insurance

Name: ______________________ PH#: ______________________

Street Address: ______________________ City/State/Zip: ______________________

By signing below I acknowledge that all of the above information is true and accurate.
If at any time any of this information changes, I am aware that I must inform the facility immediately.

Patient/Guardian: ______________________ **Date:** ______________ Photo ID Checked by: ________