COAST PHYSICAL THERAPY

Mark Tonkins, P.T., ATC

Patient Information

Name: _____ Date of Birth: _____ Sex: Male: ☐ Female: ☐

Address: _____
Street City State Zip Code

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

Last 4 of Social Security Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____ Relationship: _____

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

Occupation: _____

Name of Employer: _____ Phone: (____)_____

Address of Employer: _____ City: _____ State: ____ Zip: _____

Referring Physician: _____

Primary Care Physician (If applicable): _____

AUTHORIZATION

I HEREBY AUTHORIZE COAST PHYSICAL THERAPY TO RENDER TREATMENT TO ME AS ORDERED BY MY PHYSICIAN. I AUTHORIZE REALEASE OF ANY AND ALL INFORMATION NECESSARY FOR INSURANCE REMIBURSEMENT TO THE SOCIAL SECURITY ADMINISTRATION, ITS INTERMEDIARIES OR TO THE APPROPRAITE INSURANCE CARRIER. **I UNDERSTAND AND AM ULTIMATELY RESPONSIBLE FOR SERVICES RENDERED AND NOT COVERED BY MY INSURANCE CARRIER. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.**

_____ _____ _____
SIGNATURE DATE WITNESS