HANSEN THERAPEUTIC SERVICES, Inc.
PATIENT INFORMATION
Please Print **PLEASE COMPLETE ALL INFORMATION**

_____ ***OFFICE USE ONLY***
First Middle Last Nickname/AKA

Patient I.D. Number_____

_____ ---
Address: Street/P.O. Box Number

_____
City State Zip

_____(_____)
Home Phone Work Phone Cell Phone EMAIL ADDRESS

_____
PERSON TO CONTACT IN CASE OF EMERGENCY: Phone Relationship

_____
PATIENT'S JOB TITLE: PATIENT'S EMPLOYER:

_____
EMPLOYER'S ADDRESS: STREET CITY STATE ZIP

DATE OF BIRTH: ____________________Male / Female_____
MONTH DAY YEAR Circle

_____
REFERRING PHYSICIAN: PRIMARY COMPLAINT

_____
DATE OF ONSET:

Were you injured at work? YES NO If YES, date of Injury_____
Were you injured in an auto accident? YES NO If YES, date of Accident_____

If **YES** to either of the above questions, please inform our front desk staff; additional forms will be provided.

Assignment & Release: I authorize physical therapy treatment for myself (or my dependant). I authorize my insurance benefits be paid directly to the physical therapist. I am financially responsible for any unpaid balance. In the event any action should become necessary to collect an unpaid balance due for services rendered to me or my family, I agree to pay collection fees, reasonable attorney's fees, court costs and finance charges. A finance charge of 1.5% per month may be assessed on any unpaid balance. I authorize the physical therapist to release any information required to process this claim.

Signature:_____ Today's Date:_____