The Hand & Physical Therapy Center Of Marin
A Physical Therapy Professional Corporation

Name of Patient		Date	
Responsible Party		☐ Male ☐ Female	☐ Marital Status
Address	City	State Ca	ZIP
Home Phone		Work/Cell Phone	
Social Security Number		Date of Birth	
Dominant Hand ☐ Right ☐ Left		Email	
Physician		Referred By	

Diagnosis

Date of Injury		Date of Surgery	
How injured			
Workman's Compensation		Claim # Adjuster Phone #	
Employer Phone #		Occupation	
Employer Address	City	State	ZIP
Insurance Phone #		**Medicare** Medicare #	
		Medicare	
PPO HMO HSA		SNF Out Patient Home Health Hospital	
Member # Group #			

In Case of Emergency

Name	Relationship Phone #

I would like an appointment reminder via text Yes_____ No_____ or Email Yes_____ No_____
I authorize The Hand & Therapy Center of Marin to leave a message on my answering machine Yes_____ No_____
I authorize The Hand & Physical Therapy Center of Marin to discuss my condition with another person Yes____ No____
If yes, The Hand & Physical Therapy Center of Marin may discuss my condition with_____

I authorize The Hand & Physical Therapy Center of Marin to use and disclose information about my medical diagnosis and treatments for the purpose of treatment, payment and health care operations.

Signature

Eval Therapist	Appointment Date	Appointment Tiime