



PATIENT INFORMATION

NAME: Last First M.I.

Address: City: State: Zip:

Date of Birth: Sex: SSN: / /

HOME PHONE: CELL PHONE: E-Mail:

ADDITIONAL CONTACT NAME & NUMBER:

Marital Status: Employer: Work Phone: Occupation:

Spouse Name: Employer: Work Phone:

Date of Injury or recent flare up: Is this Injury from an accident? Yes or No

If yes: Do you have legal representation and who?

Dominate Hand: Right or Left

How did you hear about IPT? Please mark answer.

Insurance Doctor Employer Case Manager Family/Friend Former Patient Telephone Book

Radio TV Newspaper IPT Employee IPT Location Internet Trade Show Other

Please provide name/place of how you heard about IPT:

Doctor's First & Last Name/Fax#:

Diagnosis & #:

Doctor Follow Up:

Medicare Re-Evaluation Date (s):

Work Comp Insurance Medicare Medicaid Auto Accident Legal Cash

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: Relationship:

Name: Relationship:

Name: Relationship:

Patient or Authorized Agent/Representatives Signature: Date: