Prime Physical Therapy

7516 Iron Bar Lane
Gainesville, VA 20155
Phone: (571)-261-9234
Fax: (757)-720-8323

Full Name: _____ Date of birth: _____

Address:_____ City: _____ State:_____ Zip Code: _____

Phone: _____ Email: _____ Sex at Birth: F / M

Social Security Number: _____ Referring Physician: _____

Primary Care Physician:_____ How did you hear about us?_____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Primary Insurance: _____Policy/ID Number: _____Group #: _____

Policy Holder Name:_____ Policy Holder Date of Birth: _____

Policy Holder SSN: _____

Secondary Insurance: _____Policy/ID Number: _____Group #:_____

Policy Holder Name (If different than above):_____ Date of Birth:_____

Work Comp

Work Comp Claim Number:_____

Adjuster Name: _____Phone: _____ Fax: _____

Case Manager: _____Phone: _____ Fax: _____

By signing below, I acknowledge that all of the above information is accurate. I have supplied copies of all of my health insurance cards to the front desk upon registration. I understand that if my health insurance is not on file or I fail to supply the correct insurance information, I may be responsible for all balances. If at any time any of this information changes, I am aware that I must inform the facility immediately to avoid unnecessary patient balances.

Patient/Guardian Signature: _____ Date: _____