PHYSICAL THERAPY
at Walmart Health with HPRC

PATIENT INFORMATION SHEET

Referring Doctor _____ Primary Care Provider _____
What part of the body are we treating? _____

Personal Information

First Name _____ Middle Initial _____ Last _____ Nickname _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
SSN _____ - _____ - _____ DOB ___ / ___ / ___ Gender M___ F___ Marital Status Married ___ Single ____
Height __ foot, __ inches Weight _____ Are you disabled? Y__ N __ If yes, what is your disability _____

Employer _____ Occupation _____ Phone (____) _____
Emergency Contact _____ Relationship _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____

Can we communicate with you by Email? Yes / No Email address _____ (optional)

Insurance Information

Primary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __ / __ / _____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

Secondary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __ / __ / _____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

***If this is an approved claim through Worker's Compensation, please answer the following*:**
Injury Date _____ Employer when injury occurred (if different) _____
Insurance Carrier Name _____ Contact/Adjuster _____
Claim Number _____ Adjuster's Phone (____) _____

***Please complete this section if the patient is a Minor and/or covered under parent's insurance*:**
Mother's Name _____ Phone (____) _____ SSN __ __ __ - __ __ - __ __ __ __
Address (if different) _____Employer _____
Father's Name _____ Phone (____) _____ SSN __ __ __ - __ __ - __ __ __ __
Address (if different) _____ Employer _____

Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.

Signature: _____ Date: _____