ALIGN THERAPY

PATIENT INFORMATION			SPOUSE/GUARDIAN INFORMATION		
Name: Last	First	Middle	Name: Last	First	Middle
Social Security #	Date of Birth	Age	Social Security #	Date of Birth	Age
Marital Status		Sex M / F	Marital Status		Sex M / F
Street Address			Street Address (If different from patient)		
City	State	Zip Code	City	State	Zip Code
Email Address			Email Address		
Primary Phone	Secondary Phone		Primary Phone	Secondary Phone	
Email Address					
Emergency Contact		Primary Phone			

Insurance Information

Insurance Name: ID/Member Number:

Guarantor Name: Guarantor Birthdate:

How did you hear about Align Therapy?

Physician Referral	Family/Friend	Returning Patient	Employee Referral
Insurance	Google	Facebook	Website
Mailer	Newspaper	Sign	Other: ____________________

REFERRAL AND OTHER IMPORTANT INFORMATION
Name of Referring Physician:
Primary Care Physician, if different from above:
Medical Reason for Physical Therapy:
If Accident, where did it occur? Work – Home – Auto – Other

Are you currently under home health care? Y N

I do attest that the above information is accurate and correct to the best of my knowledge.

Signature: ____ **Date:** ______________________

Relationship to Patient: ________________________________

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