CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.

MINOR PATIENT INFORMATION RECORD

PATIENT NAME		DATE

NAME YOU PREFER TO BE CALLED	PATIENT BIRTH DATE	SEX ☐ MALE ☐ FEMALE	AGE

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN	GUARDIAN BIRTH DATE	SOCIAL SECURITY # (REQUIRED FOR INSURANCE)

ADDRESS	APT #

CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE

EMPLOYER	OCCUPATION

EMERGENCY CONTACT NAME	PHONE NUMBER	RELATIONSHIP

EMAIL ADDRESS (FOR CLINIC UPDATES ONLY)

HOW DID YOU LEARN ABOUT OUR CLINIC?

☐ I'M A RETURNING PATIENT ☐ REFERRED BY A FRIEND ☐ REFERRED BY A FAMILY MEMBER

☐ INTERNET / CLINIC WEBSITE ☐ PHONE BOOK ☐ CLINIC SIGN ☐ MY PHYSICIAN ☐ OTHER

WHOM CAN WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE INFORMATION

INSURANCE TYPE: ☐ PRIVATE HEALTH ☐ MEDICARE ☐ MOTOR VEHICLE ☐ WORKERS COMP ☐ OTHER

INSURANCE CO	PHONE NUMBER

NAME OF INSURED	BIRTH DATE	RELATIONSHIP

CLAIM / ID NUMBER	GROUP NUMBER	DATE OF INJURY

SECONDARY INSURANCE INFORMATION

INSURANCE TYPE: ☐ PRIVATE HEALTH ☐ MEDICARE ☐ MOTOR VEHICLE ☐ WORKERS COMP ☐ OTHER

INSURANCE CO	PHONE NUMBER