CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.

PATIENT INFORMATION RECORD

PATIENT NAME	NAME YOU PREFER TO BE CALLED	DATE

ADDRESS	APT #

CITY	STATE	ZIP CODE

BIRTH DATE	AGE	SOCIAL SECURITY # (REQUIRED FOR INSURANCE)

HOME PHONE	CELL PHONE	WORK PHONE

SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER	NAME OF SPOUSE

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

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