

Capital Medical Center

Physical, Occupational, & Hand Therapy

Last Name: _____ First _____ M _____

DOB: ____/____/____ SSN _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) (____) _____ (Cell) (____) _____

Email (optional): _____

Mother's first name _____

Optional: Race _____ Religion _____

Employment Information

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Work Status: FT / PT Employer Phone: (____) _____

Emergency Contact

Name: _____ Phone: (____) _____

Relationship to patient _____

Name: _____ Phone: (____) _____

Relationship to patient _____

INSURANCE INFORMATION

PLEASE NOTE: Patient is responsible for verifying insurance coverage prior to treatment. As a courtesy, the office staff will also call your insurance company to check eligibility and benefits allowed for therapy. Please give us 1-2 weeks after your first appointment to complete this. Thank you