400 S. Reino Road, Suite #101
Newbury Park, CA 91320

reCOOPERation PHYSICAL THERAPY
SYMMETRY IN BALANCE AND MOTION

P: 805.277.2233
F: 805.277.0623

PATIENT INFORMATION

Today's Date:				
PATIENT INFORMATION (PLEASE PRINT)				
Patient's LAST Name:	**FIRST Name:**	**Middle:**	■ Mr. ☐ Miss ☐ Ms. ☐ Mrs.	
			Sex: ■ M ☐ F	
Date of Birth:	Age:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Street address:		Driver's License #:	State Issued:	
City:	State:	Zip Code:	Email Address:	
Home Phone:	Cell Phone:	Work Phone:		
Occupation:	Employer:	Employer Address:		
Insurance Subscriber Name (if different than patient) :		Subscriber DOB:	Patient Relationship to Subscriber:	
Referring Doctor		Other family members seen here (if any):		
ADDITIONAL INFORMATION				
****Please give your insurance card to the Front Desk****				
Date of Injury(if known):		Is this injury work related? ☐ Yes ☐ No		
If yes, Industrial Insurance name and address:				
If work related, employer at the time of injury:				
Is injury related to an accident?	☐ Auto:		☐ Other:	
Are you involved in a lawsuit and/or are you pursing a third party liability claim as a result of this injury?	☐ Yes ☐ No	If yes, name and address of attorney:		

I hereby irrevocably authorize payment of medical services rendered to my dependents or myself directly to Recooperation Physical Therapy. I also authorize Recooperation Physical Therapy to furnish my insurance with full information regarding treatment provided to my dependents or myself. I also understand that my insurance is billed as a courtesy, and that I am responsible for all charges not paid by my insurance within 8 weeks after billing date. I further understand that any supplies given to my dependents or myself may not be covered by my insurance; for this reason it is customary to collect supplies at the time of service. By signing below, you are confirming that all information above is truthful and filled out to the best of your ability and the photo-static copy of your insurance card is valid.

Patient/Guardian signature:	***Date:***