Patient Information

Infinity Physical Therapy
1404 Fifield Road
Pella, Iowa 50219
641.621.0044

Patient

□ Policy Holder □ Patient is a Minor

First Name _____ Last Name _____

Birth date ____/____/____ SSN _____-_____

Phone Numbers

Home _____ Cell _____ Work _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Employer _____

Family Physician _____ Referring Physician _____

How did you hear about us? _____

Policy Holder

(if different than patient)

First Name _____ Last Name _____

Birth date ____/____/____ SSN _____-_____

Phone Numbers

Home _____ Cell _____ Work _____

Address: _____

City _____ State _____ Zip Code _____

Email _____ Employer _____

Emergency Contact

Name _____ Phone Number _____

Relationship _____

By signing below:

- I acknowledge the information given on the front is correct.
- I acknowledge that HIPPA Privacy Information is available to me upon request.
- I authorize Infinity PT to leave voicemails on my answering machine regarding my care.
- If patient is a minor, I as the parent/guardian authorize Infinity PT to provide Treatment.

_____ _____

Signature of Patient or Legal Guardian Date