OLYMPIC
Physical Therapy & Aquatics

Jeff Harband, PT

Information Form

Name: _____ Date: _____
Address: _____
City, State, Zip _____
Phone: Home _____ Work _____ Cell _____
Which phone number to you prefer we use when contacting you? _____
Email Address: _____

Date of birth _____ Age _____
Social Security: _____
Occupation / Employer: _____
I live (circle one): alone with partner / spouse with friend / roommate other: _____
I was referred by: _____
Primary Physician: _____ Phone: _____
Other Physician: _____ Phone: _____
Are you seeing any other practitioners for this condition? Yes No
If so, please list: Name: _____ Type: _____
Practitioner's phone: _____ May we contact them? Yes No

Insurance Information

Primary Insurance Company: _____
Policy #: _____ Group #: _____
Relationship to insured (circle one): Self Spouse Parent
Customer Service Phone (appears on card): _____
Secondary Insurance Company: _____
Policy #: _____ Group #: _____
Customer Service Phone (appears on card): _____
Is this injury work-related? Yes No
If yes, Claim #: _____ Adjuster Name: _____
Adjuster Phone: _____
Do you have pending litigation regarding this injury? Yes No
If yes, Attorney Name: _____ Phone: _____

Please provide us with your insurance card and physician's prescription for Physical Therapy (if available) at your first visit.