Name:____ **DOB:**___________________________________

Address:____

City:___________________________ **State:**___________________ **Zip:**_________________________

Phone:___________________ **Cell:**_______________________ **SSN:**_____________________________

Referring Dr.:___________________ **Ph:**_______________ **City:**_______________________________

Return to Dr. Date & Time:___________________ **Date of injury or symptoms began**______________

Student No/Yes **Did sports injury occur at school function: No/Yes**

Employed No/Yes **If yes, Employer's name:**____

Employer's Phone: _____________________________ **Retired: Yes/No**

Marital Status: **Single** **Married** **Divorced** **Widowed**

If married, Spouse's name:__________________ **Spouse's DOB:**_______________________________

Spouse's Employer:________________________ **Have you had physical therapy this year? No/Yes**

Emergency Contact:_______________________________ **Phone:**_______________________________

Injury related to: **Auto Accident** **Work** **Home** **Sports** **Other**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to the OMNI CENTER, INC., and I realize I am financially responsible for any non-covered services, deductibles, Co-payments, or any supply. Should legal action be necessary to obtain amount due on my account at the OMNI CENTER, INC., I understand that I will be responsible for any court costs, attorney fees or any other collection fees. I have read and understand appt. and cancellation policy and HIPPA. I authorize the OMNI CENTER, INC. to release any information required by the insurance company in the processing of this claim. I give my consent to be treated for Physical Therapy or Occupational Therapy.

Patient's Signature:_________________________________ **Date:**______________________________

If Patient is a minor-Parent of Guardian's Signature/Date:____________________________________