Pillars Physical Therapy
and Wellness Center

2nd Floor, Suite D, 307 87th St.,
87th Street Plaza Daly City, CA 94015
Tel: (650) 550-0050 • Fax: (650) 550-0070
www.pillarspt.com

DATE: APPOINTMENT DATE:

Patient Information

REFERRING PHYSICIAN	LAST NAME	FIRST NAME, INITIAL	DATE OF BIRTH

CONDITION TO BE SEEN FOR	SOCIAL SECURITY NO.	DRIVERS LICENSE NO.	SEX ☐ M ☐ F	MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED

ADDRESS	CITY	STATE	ZIP CODE

EMAIL ADDRESS	OCCUPATION	HOME PHONE	WORK PHONE	CELLPHONE

EMPLOYER	EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

Responsible Party Information Other Than Patient

RESPONSIBLE PARTY OR CUSTODIAL PARENT	GUARANTOR NAME (LAST, FIRST,MIDDLE)	SOCIAL SECURITY NUMBER

DATE OF BIRTH	SEX ☐ M ☐ F	HOME PHONE	WORK PHONE	CELLPHONE	RELATION TO PATIENT

ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

Emergency Contact

CONTACT NAME	RELATION TO PATIENT	HOME PHONE	WORK PHONE	CELLPHONE

I Understand that regardless of my insurance, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Pillars Physical Therapy on my behalf for any unpaid services rendered by Pillars Physical Therapy.

SIGNATURE	DATE

Insurance Information

TYPE OF INSURANCE: ☐ AUTOMOBILE ☐ HEALTH ☐ SELF PAY ☐ WORKERS' COMP. ☐ OTHERS _____

PRIMARY INSURANCE COMPANY	PHONE NUMBER	GROUP NUMBER	ID/SS NUMBER

EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)	SUBSCRIBERS NAME	SUBSCRIBERS DATE OF BIRTH

PRIMARY INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

DEDUCTIBLE	DEDUCTIBLE BALANCE	YEARLY OR LIFETIME MAX	MAX YEARLY VISITS	CO-PAY

SECONDARY INSURANCE COMPANY	PHONE NUMBER	GROUP NUMBER	ID/SS NUMBER

EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER (INSURED)	SUBSCRIBERS NAME	SUBSCRIBERS DATE OF BIRTH

SECONDARY INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE

CASE MANAGER	PHONE	FAX	ADJUSTER	PHONE	FAX

CASE/CLAIM NO.	CLAIM BILLING ADDRESS	DATE OF INJURY

CONTACT PERSON	NOTED BY

HOW DID YOU HEAR ABOUT US? ☐ FAMILY/FRIEND ☐ WEB ☐ ADVERTISEMENT _____ ☐ OTHERS _____