KAMIN PHYSICAL THERAPY

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____

Sex: ☐ Male ☐ Female ☐ Non-Binary Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ Apt. #: _____

City, State, Zip: _____

Cell Phone: _____ Home Phone: _____

E-mail: _____

Patients receive reminders for their appointments 2 days prior. Do you prefer: ☐ Text messages ☐ Phone Calls

If you obtain a bill, do you prefer to receive an invoice via: ☐ Mail ☐ E-mail

Responsible Party (If someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Birth Date: _____ Cell Phone: _____ Home Phone: _____

Primary Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Address: _____

Employer Providing Primary Insurance: _____ Employer phone #: _____

Employer Address: _____

Secondary Insurance Information

Name of Insured: _____ Insured Birth Date: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company: _____ ID #: _____ Group #: _____

Insurance Address: _____

Employer Providing Secondary Insurance: _____ Employer phone #: _____

Employer Address: _____

I hereby authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for the entire bill.

OFFICE USE ONLY: Dr: _____ NPI: _____

DX: _____ 2026 Update

Signed: _____ Date: _____

Printed Name: _____

OFFICE USE ONLY: Dr: _____ NPI: _____

DX: _____ 2026 Update