Beeville Physical Therapy, PLLC

General Information

Please Print

Patient's Name: Last: __________________________ First_____________________________ MI: _____

Birth Date: ____________________ Gender: ________ Age: __________ SS#: ___________________

Mailing Address: ____

City: ______________________________________State: _____________________ Zip: _____________

Physical Address: ____

City: ____________________________________ State: ______________________ Zip: ____________

Cell Phone: _(______)______________________ Home Phone: _(______)_______________________

Work Phone: _(_____)_____________________________Ext: ___________

Email Address: ____

Patient Employer: ______________________________ Business Address: ______________________

Spouse's Name: Last: __________________________ First: __________________________ MI: ______

Emergency Contact: ____

Phone: _______________________________ Relationship: ___________________________________

Responsible Party (If other than above):____

How would you like your appointment reminder? Voice Message _________Text Message__________

Primary Care Physician ____________________________________Phone: ________________________

Financial Responsibility

I authorize payment to be made directly to Beeville Physical Therapy, PLLC for all services rendered. I understand that payment for services rendered to Beeville Physical Therapy, PLLC and its staff is expected at the time of services unless arrangements are made in advance. I also understand that there is not guarantee of payment or coverage by my insurance company and that any balance incurred for services is the responsibility of the patient or legal guardian.

I, _________________________________, am signing that I am aware of financial responsibility for all services rendered.

Patient/ Legal Guardian: ____Date: ____________________