



www.physicaltherapyky.com

Elizabethtown Clinic

1222 Woodland Drive
Elizabethtown, KY 42701
(270) 234-1569

Hodgenville Clinic

104 E. Main Street STE 104
Hodgenville, KY 42748
(270) 358-9765

Bardstown Clinic

115 S. Salem Dr.
Bardstown, KY 40004
(502) 350-0880

Radcliff Clinic

800 W. Lincoln Trail Blvd.
Radcliff, KY 40160
(270) 352-1061

South Louisville Clinic

4331 Churchman Ave.
Louisville, KY 40215
(502) 366-1773

Name _____ S.S.# _____
Address _____ City _____ Zip _____
Phone _____ Age _____ Date of Birth _____ Sex: ___M___F Marital Status _____
Referring Physician _____ Primary Physician _____
Employer _____ Occupation _____
Business Address _____ Business Phone _____
Name of Spouse (if applicable) _____ S.S.# _____
Spouse Employer _____ Phone _____
EMAIL Address _____ Cell Phone # _____

Emergency Contact

Name of Person Not Living With You _____ Phone _____
Relationship _____ Address _____

Medical History

_____ Diabetes _____ Blood Clots In Legs _____ Heart Problems
_____ Lung Problems _____ Knee Replacement _____ Hip Replacement
_____ Knee Surgery _____ Shoulder Surgery _____ Neck Surgery
_____ Back Surgery _____ Latex Allergy _____ Osteoporosis

Please List Any Other Medical Conditions _____

HAVE YOU HAD HOME HEALTH CARE IN THE LAST 30 DAYS? IF YES, WHAT AGENCY _____

Primary Insurance

Is Your Condition Work Related? ___Yes___No Auto Accident? ___Yes___No Date of Injury _____
Insured/Suscriber _____ Relation to Patient _____
Address (if different from patient) _____
Subscriber's S.S.# _____ Subscriber's DOB _____ Insurance Company _____
Insurance ID # _____ Group # _____

Additional Insurance

Is patient covered by additional insurance? ___Yes___No Subscriber's Name _____
Address(If different from patient) _____
Insurance Company _____ ID# _____ Group # _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Physical Therapy Associates, Inc. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney fees. I hereby authorize this health care provider to release all information necessary to secure payment of benefits. I understand that I have the right to choose my Physical Therapy provider and have chosen this facility and hereby give my consent to treatment. I further agree that a photocopy of this agreement shall be valid as the original.

Patient Signature _____ Date _____

Under 18 Parent Signature Required

Parents Name _____ Address _____

Employer _____ Phone _____

Parent Signature _____