MIAMI PHYSICAL THERAPY ASSOCIATES INC.

2869 SW 27 Avenue • Miami, FL 33133
Tel: 305-444-0074 • Fax: 305-444-8503
www.miamipta.com

PATIENT INFORMATION

Date: _____

Name: _____
Last First Middle Initial

Telephone Number (Home): _____ Telephone Number (Mobile): _____

Email: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: □ M □ F Date of Birth: _____ □ Single □ Married □ Widow □ Divorced

Employer: _____ Occupation: _____

Business Address: _____ Telephone Number (Business): _____

Date of Injury: _____ Employment Injury: Yes / No Last Visit to Doctor: _____

In case o fan emergency, whom should we notify? _____

Telephone Number: _____ Relation to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have _____ as my insurance company/ies
Name of Insurance Company/ ies
and assign directly to Miami Physical Therapy Associates, Inc all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Miami Physical Therapy Associates, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature of Responsible Party Relationship Date