Batesville Therapy Clinic
Patient Data Sheet

***Patient Name:** ____ * Date of Birth____________ *Age ____
Last First MI

*Mailing Address ____ *City/ST ________________ * Zip________

*Phone # ____________________ Cell __________ * Sex _____ Marital Status _____ *SS#____________________

*Employer ___________________________ Phone # _________________ * Referring Physician______________

***Emergency contact** ________________________ *Phone #_________________ *Family Physician ____________

*Address____
Street Address City/State/Zip

***Parent/Guardian of minor** ______________________________ * Phone # _______________ *SS#_____________

*Address ____ City/State __________________ Zip __________

*Employer ____ Work # _________________________

***Have you received speech, physical or occupational therapy at a facility or in your home this calendar year?** ________

***How did you hear about our clinic?** ____ **Physician** ____**Friend** ____**Newspaper/other media**
____**BTC Employee** ____**Former Patient**

***Please check appropriate and list name:** ____

***REASON FOR VISIT**

*Please check reason for visit: Illness ______ Accident _____

*If illness, please provide date of onset ___________ or date of surgery___________

*Please check type of accident: Auto______ Job ______ Home ______ Recreational ______

*Date of accident: ______________ Time: ________

*Please provide description of accident : ____

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INSURANCE INFORMATION

Please provide our office with a copy of your insurance card

*Primary __________________________________ *Secondary ____________________________________

*Policy Holder ______________________________ *Policy Holder _________________________________

*I.D. Number _______________________________ *I.D. Number ___________________________________

*Group Number _____________ *DOB___________ *Group Number __________________ *DOB__________

****If this is a Work Comp claim, please provide us with the following:***

*Name of Insurance Company__________________________________ *Claim Number___________________________

*Mailing Address____

*Phone Number ___________________________ Fax Number_________________ Adjustor ___________________

****Required***

Please See Other Side ⇨