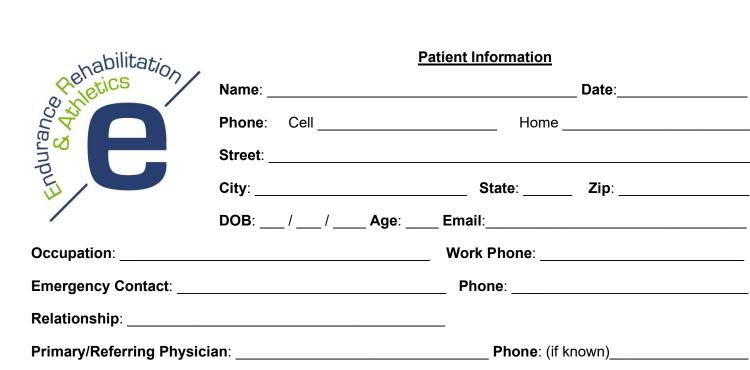
Patient Information



DOB: / / Age: Email: Occupation: _____ Work Phone: _____ Emergency Contact: Phone: Primary/Referring Physician: _____ Phone: (if known) Who May We Thank for Referring You to ERA? _____ Injury/Reason for needing PT: Have you received Physical Therapy for this, or another, condition this calendar year? Yes / No **Home Environment**: Do you live alone? Y / N , If not, with whom? Do you live in a Single or Multi-level Home? into home_____ to basement____ to second level_____ Number of Railings: into home_____ to basement____ to second level____ Is this injury due to an auto accident or worker's compensation?Y /N Claim Filed?Y / N Name of auto/work comp adjuster/manager: Claim # Phone: _____ Fax:

Primary Insurance Company: _____ ID# Phone# Name of Insured: ______ DOB: ____ / ____ Relation: _____ Secondary Insurance Company: _____ Name of Insured: ______ DOB: ____ / ____ Relation: